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Exploring ADHD Identity Development and Evolution in Adults

Section A: How do adults with attention deficit hyperactivity disorder (ADHD) use online communication platforms to learn about and discuss ADHD?

Word Count: 6836 (plus 245 additional words)

Section B: Interactions in identity development in trans and gender-diverse adults with ADHD: an abbreviated grounded theory design

Word Count: 7009 (plus 344 additional words)

Overall Word Count: 13,845 (plus 589 additional words)

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

2025

SALOMONS INSTITUTE
CANTERBURY CHRIST CHURCH UNIVERSITY

Acknowledgements

Thank you to all the participants for their generosity in taking part. I hope this project can help connect more dots, foster conversations, and has done justice to your stories.

Thank you to my supervisors and consultants for their reflections, wisdom, and patience.

A special thank you to everyone in my life who played a part in holding me up and cheerleading for me when life forced me off-course.

…And to my muse and my love - what can I say? Simply, thank you for everything. Thank you for being unapologetically you. And for serving me air-fryer dinners.

Summary of the Major Research Project

Section A

A systematic literature search of ADHD adults' engagement with social media was completed, which included critical appraisal and thematic synthesis. 11 studies published between 2012 and 2024 were reviewed. Findings revealed that online platforms foster shared experiences, identity development, and empowerment. However tensions surrounding the validity of ADHD expertise and societal expectations were indicated. Methodological limitations were observed, including reliance on publicly available online data and heterogeneity in design and analysis. Clinical implications include the importance of integrating online narratives into the knowledge and language used when working with ADHD.

Section B

A grounded theory methodology was used (Corbin & Strauss, 2015) to explore the identity development of transgender/gender-diverse adults with ADHD. Data was collected through eleven interviews and an abbreviated grounded theory model was developed to understand interactions in identity development. A model and theory reveal how societal structures and stigma contribute to internalised shame, stigma, and trauma. Access to knowledge and supportive communities emerged as processes for resistance and were linked to mental wellbeing. Clinical and research implications are included.

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Section A: Systematic literature review

How do adults with attention deficit hyperactivity disorder (ADHD) use online communication platforms to learn about and discuss ADHD?

Word count: 6836 (plus 245 additional words)

Abstract

This section employed a systematic literature search, which included critical appraisal and thematic synthesis, to examine how adults with ADHD engage with social media and online communities. 11 studies published between 2012 and 2024 were reviewed. Findings revealed that online platforms foster shared experiences, identity development, and empowerment but also highlight tensions surrounding the validity of ADHD expertise and societal expectations. Methodological limitations, including reliance on publicly available online data and heterogeneity in design and analysis, were noted. Clinical implications include the importance of integrating online narratives into the knowledge and language used when working with ADHD. It also includes the recognition of the influence of these spaces for self-understanding, connection and redistributing power.

Keyword(s): ADHD; Online Communication; Social Media; Identity; Diagnosis

Introduction

Attention deficit hyperactivity disorder (ADHD) has garnered increasing interest across public discourse, clinical practice, and academic research. This has included literature exploring the sharing of information and experiences about ADHD using social media and online communication platforms. There have been concerns raised about problematic social media use, particularly in young people (Settanni et al., 2018), and associations between time spent and increase in traits of attention difficulties and impulsivity (Thorell et al., 2024; Dekkers & van Hoorn, 2022).

ADHD: Diagnostic and conceptual understandings

Contemporary Western perspectives conceptualise ADHD as a neurodevelopmental presentation that develops in childhood. It would not be possible within the scope of this review to provide a comprehensive diagnosis criteria of Attention Deficit Hyperactivity Disorder (ADHD) according to the revised edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) (American Psychiatric Association [APA], 2022). In brief, to receive a diagnosis in adulthood, “five or more symptoms” of inattention and/or hyperactivity are required, with evidence of symptoms before the age of 12 years old

ADHD has previously been considered something that “resolves” through adolescence and young adulthood (Rivas-Vasquez et al., 2023); current understandings in the DSM-5 acknowledge that in one-half to two-thirds of children continue to experience ADHD traits in adulthood (APA, 2022; ibid). Notwithstanding the DSM-5 diagnostic guidelines, there has been difficulty ascertaining clinical and professional consensus on what ADHD is (Timimi & Taylor, 2004). The criteria for ADHD has gone through continued addition of concepts such as expanding understandings to include emotion regulation differences (Sklepníková & Slezáčková,

2022. Its conceptualisation and evidence has been criticised by some as unscientific due to conceptualisation of ADHD as circular reasoning (Moncrieff et al., 2014; Whiteley, 2014) with limited physiological evidence. Increasing diagnosis rates have also been attributed, in part, due to widening inclusion criteria and potential influence of pharmaceutical companies (Whitely, 2015). This entered popular public and healthcare discourses following the British Broadcasting Corporation *ADHD Clinics Exposed* Panorama documentary *(*Carson et al., 2023). Clinicians also appear to differ in how they characterise its presentation (Nigg et al., 2021).

Findings from cognitive neuroscience and genetics have dominated media representations of ADHD and have captured the popular imagination as an explanation for human behaviour and nature (Comstock, 2015). These have formed parts of the dominant common-sense or "lay" ways of understanding ADHD in the self or others. Evolving understandings consider ADHD within biopsychosocial-cultural frameworks, acknowledging relationships between biological predispositions, socio-cultural influences, and psychological factors in its expression and management (Pham, 2015; Sklepníková & Slezáčková, 2022). In particular, the neurodiversity paradigm is developing in its shared lay and theoretical understandings, as well as its popularity.

Alternative development of understandings and conceptualisations: the neurodiversity paradigm

Neurodiversity is defined as "… the diversity of human minds … a natural and valuable form of human diversity …" (Walker, 2021, p. 30-31). The term was first coined by Singer (1999, as cited by Walker, 2021) where she suggested that neurodiversity represents a new social category (similarly to gender, race, or sexual orientation).

Discussions around neurodiversity often also incorporate the social model of disability, whereby disability is understood as the societal attitudes and norms, systemic barriers and failure to make accommodations that disable neurodivergent people (Walker, 2021). The neurodiversity paradigm and movement aligns with shifting focus from deficit-focussed or abnormal-normal binary views of mental health that aim to return behaviours to a societally enforced baseline, to approaches such as Seligman and Csikszentmihalyi's (2000) positive psychology that emphasise positive aspects of human functioning and flourishing (i.e., positive emotions, engagement, relationships, meaning and accomplishment) (Seligman, 2012). However, despite the increasing prevalence of the neurodiversity and positive psychology perspectives, Sedgwick et al. (2018) highlight the paucity of research exploring the positive aspects and attributes of ADHD, with research typically focussed upon medication as the means to live a "successful" life.

Self-Identification of ADHD

There is increasing self-identification with ADHD, or the recognition and labelling of cognitive, emotional and behavioural traits and patterns as aligning with ADHD (Stenner et al., 2019; Hendrix, 2024). This can be whilst waiting to complete an assessment, where there are increasingly long wait-lists and costs associated with private diagnosis (Stenner et al., 2019), and concerns regarding barriers for women (Merrick, 2023; Climie & Attoe, 2023) and rigour of assessment (Carson et al., 2023). Others may not want to seek a diagnosis, including perceived stigma (Merrick, 2023; Climie & Attoe, 2023), and limited benefits and scepticism of the medical approach (Honkasilta, 2016).

The landscape of current lived-experience ADHD research

Research to date has been dominated by a focus on children and the observed behaviour of male children in particular; more boys than girls being diagnosed by ratios up to 10/1 in clinical settings (Williamson & Johnston, 2015). Recent years have seen a large increase in the number of adult diagnoses. The overwhelming majority of the literature has taken a third-person perspective on ADHD-related lived and living experiences, gathering knowledges from educators, clinicians, and particularly caretakers (Lisitza, 2022). It follows that research on identity development in adults with ADHD also remains limited (Schott, 2012). Emerging studies suggest more people are claiming ADHD as a part of their self-concept (Stenner, O'Dell & Davies, 2017). Qualitative studies using interviews and observations from online blogs and message boards suggest people simultaneously distance themselves from their ADHD by locating it within their brain and as "*the* ADHD" (Nielsen, 2017); they also identify their experiences as part of the spectrum of human experience and neurodivergence (Nielsen, 2017; Thelwall et al., 2021) with positive attributes (Shaw, 2021).

The use of the internet to shift the ownership of knowledge production

The internet has played an important role in the increasing visibility and strength of lived experience or service user involvement in mental health services, and disability rights, with particular emphasis on facilitation of online community formation (Neal, 2006). Similarly, it has played an important role in developing lay expertise and peer support in other forms of so-called "contested diagnoses" such as fibromyalgia (Barker, 2008). Increasingly there are clinicians, researchers, and academics who are open about their own neurodivergent identity (Mellifont, 2023). However there are critiques to the neurodiversity movement which cannot be discussed at length here, but include potential increasing expansion of the concept and reinforcement of diagnosis categories (Cromby & Johnstone, 2024).

Using the internet for identity development and expression

There is an increasing use of online communication platforms. Joinson (2001) argues that computer-mediated communication corresponds with high levels of self-disclosure, such that "as the Internet becomes a ubiquitous part of people’s lives, so psychologists will increasingly need to include the medium as well as the person in any analysis of social behavior” (p.190).

Social media use has been suggested to support identity exploration and validation, freedom of expression, and development of social connections and community (Mikami et al., 2015). This has included identities where the availability of physical spaces or community are not always available, such as disabled LGBTQ students (Miller, 2017). However some users report prevailing discourses about the validity of online spaces and communities as “not real”, or lesser to in-person interactions (Miller, 2017).

Users can also be excluded explicitly from online spaces through discrimination such as racism or transphobia. Neurodivergent communities and online communication use has been explored in the research literature, for example the use of online autistic communities and narratives (Betts et al., 2023). There are positive correlations between (moderate) use of Facebook and happiness in autistic adults (Ward et al., 2018). However studies that focus upon the experience solely or predominantly of engaging with ADHD is less prevalent.

Social media use has been studied to explore third-person perspectives of those who live with someone with ADHD, particularly amongst parents and caregivers of children with ADHD. These communities have been formed to seek knowledge and resources, support, and alleviate feelings of guilt, isolation and shame (Lisitza, 2022). First-person perspectives have largely focussed upon the experience of adolescents. Childhood ADHD was found to predict at follow-up in emerging adulthood a greater preference for online social communication compared to in-person, and a greater tendency to have used online methods to interact with strangers (Mikami et al., 2015). Adolescents with ADHD have been suggested to use the supportive environment of online groups to develop positive self and group identity, and reject common negative stereotypes and stigma. People with ADHD have been found to have higher engagement with Twitter.com (Guntuku et al., 2019), where computational analysis reported themes of tweeting about emotional dysregulation, self-criticism, substance use, and exhaustion.

ADHD: Co-occurrences and Diagnostic Overlap

ADHD often co-occurs with conditions such as anxiety, depression, autism, and learning difficulties, which can interact in complex ways to shape self-concept and engagement with diagnosis (Thapar & Cooper, 2016). This review focuses on ADHD in adults due to the limited research available as previously described; however, many individuals sharing online narratives may also be navigating overlapping or intersecting difficulties.

Rationale for review

Systematic reviews already exist around attitudes of children and adolescents' use, and parents of ADHD children. Systematic reviews also currently exist for analysis of social media accuracy, and trends of how people discuss others who live with ADHD. There are potential important clinical implications for understanding the use of social media and online narratives. These spaces provide the means for users to write, share and receive feedback on their personal narratives. The process of formation of a narrative has been found to improve mental and physical health (Pennebaker & Seagal, 1999). Kang et al. (2016) conclude that YouTube provides personal storytellers with an opportunity to voice social responsibilities about health. Social media for health information may invoke the heightened awareness, attention, and engagement with ADHD at both the personal and wider societal levels such as the need for governmental assistance.

The role of electronic support groups and communities have been explored in other diagnoses which have been considered medically uncertain or "contested" such as fibromyalgia

(Barker, 2008). These revealed the growing influence of expertise held within these communities, and how this may challenge dominant beliefs or practices of clinicians. This led to concerns of increasing medicalisation or “consumer demand” of diagnosis-seeking. At the same time, individuals become empowered. As described above, ADHD has undergone similar contestations. Understanding these processes, including tensions or discrepancies that may be present within these communities, could further our shared understanding of ADHD and what types of support could be beneficial. Therefore the current review intends to explore the following questions: (1) How do adults with ADHD access social media such as online platforms and online communities?; and regarding ADHD lived and living experiences, (2a) What are the shared experiences of ADHD, and are there expressed tensions or disagreements online? (2b) Are there particular processes that maintain or resolve difficulties in the formation and synthesising of ADHD knowledges?

Methods

Literature search strategy

A search was conducted in January 2024 using the following databases: Medline; PsycINFO; and Web of Science. The Open Access Theses and Dissertations database, including forward and backward citation searching, were used to gather additional “grey literature”. Search terms were selected following preliminary searches, and search terms used in similar studies. No additional filters were applied. See Table 1 for key terms.

Key terms

Table 1

Search terms with Boolean operators

	Search Terms
ADHD	“attention deficit hyperactivity disorder” OR “Attention-Deficit/Hyperactivity” OR ADHD OR “attention deficit disorder”
	AND
Online communication platform	“social media” OR “social network*” OR “digital media” or “social platform*” OR “online communicat*” OR “online communit*” OR “online social communic*” “social media communit*” OR “ADHD communit*” OR Facebook OR Instagram OR OR Myspace OR YouTube OR Reddit OR Twitter OR Tiktok OR OR “message board*” OR “online forum*” OR cyber OR “digital technolog*” OR “online narrative*” OR “online stor*” OR “digital stor*” OR “digital narrative*”

Inclusion and exclusion criteria

Inclusion and exclusion criteria were decided upon following preliminary searches through the results. As above, the overwhelming majority of qualitative research explored the experiences of adolescents, parents and caregivers, or general perceptions of ADHD. There were quantitative studies which focussed upon correlational and regression analyses of social media/online community use and interactions, such as time spent online and the number of responses or “likes and dislikes” to assess active engagement. A number of studies sought to seek out predictive relationships between social media use and ADHD symptoms, though it was unclear whether this was to identify broader cultural explorations about reduced attention span associated with digital technology (and not specifically ADHD). Lastly, there were studies which explored “problematic internet usage” or “internet addiction” and ADHD. For the final inclusion and exclusion criteria, see Table 2.

Table 2

Inclusion and exclusion criteria

Inclusion Criteria	**Exclusion Criteria**
Majority of participants were aged at least 18 years, or online interactions were otherwise reasonably believed to come from adults	Studies focused upon children or adolescents
First-person narratives of adults, where content is predominantly or solely about ADHD (diagnosed or self-identified ADHD).	Mental health studies without disaggregation for ADHD
	Studies that focus upon related others' perspectives, such as parents, adult partners, or otherwise cohort attitudes about *others* with ADHD. Studies to be excluded if they do not separately report upon first-person use of social media or narratives shared.
Qualitative or mixed-methods studies which report upon the natural use of online social media communication. Studies report directly or indirectly (such as discourse analysis) upon use of online communication	Social media use that is predominantly one-to-one or not publicly accessible e.g. WhatsApp, Snapchat, Zoom.
	Studied an intervention such as online coaching
	Quantitative studies
	Review articles, book chapters

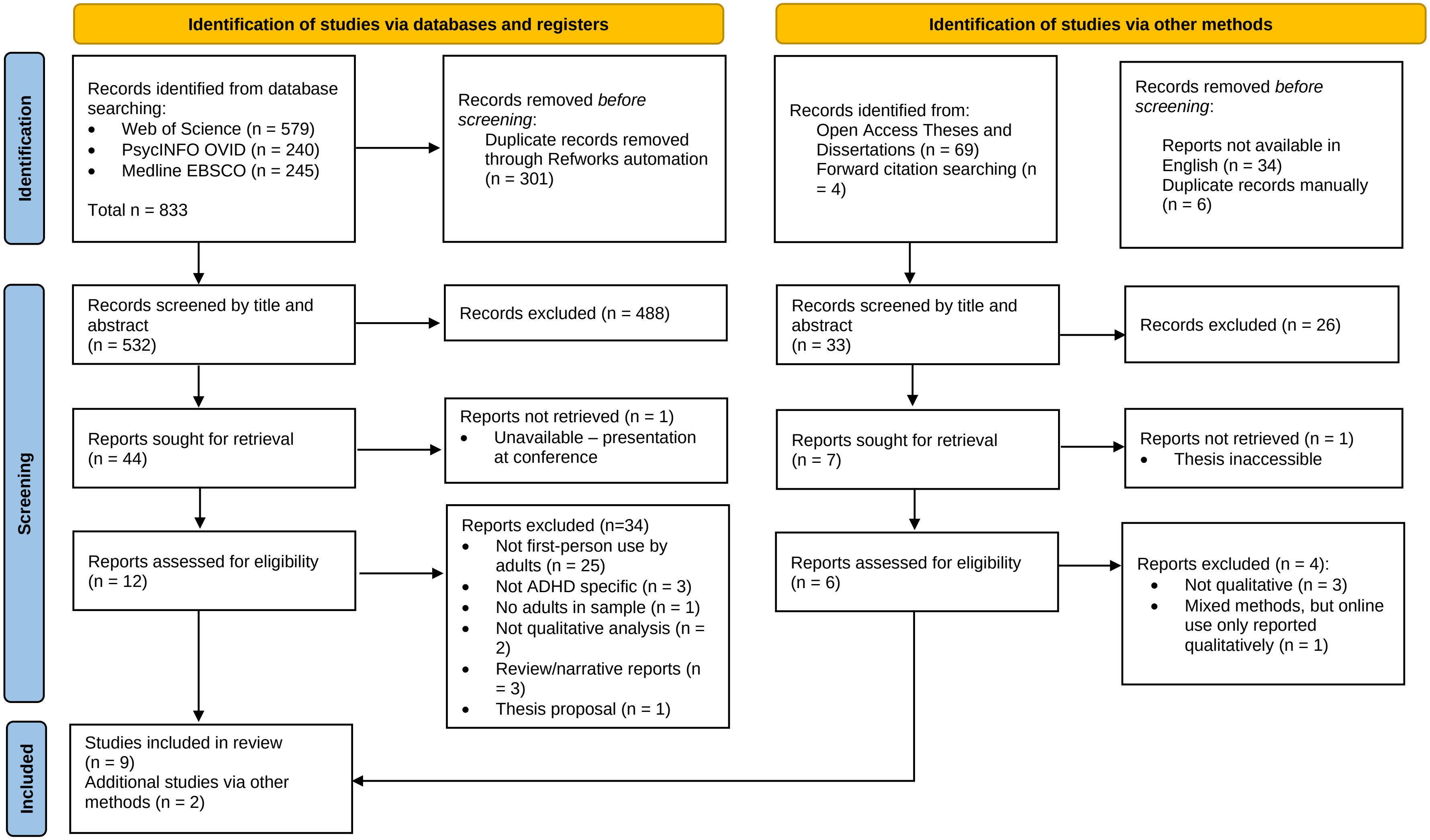
Online communication is mostly about ADHD	Not about general patterns of use (e.g.) hours spent, timing of posts, likes or dislikes on posts
Participants with experiences of other form of neurodivergences such as autism, only if the frequency of each form of neurodivergence in the sample is reported separately	ADHD not disaggregated in results from other neurodivergent experiences such as autism (i.e.) “neurodivergent participants”
Reports impact of online communication platforms to discuss ADHD	Reports predominantly upon, or does not make distinct, the impact of in-person communication or communities
	Internet or mobile phone use more generally, including gaming (where communication is not about ADHD) or pornography
	Review or narrative articles, book chapters
Any date	
Any country	Report not published in English

Selection of studies

Studies which explored the experiences of adolescent students such as Gajaria et al., (2011) were not included. Studies were also not included if they used online communities and narratives as a means to explore the intersection of ADHD and other aspects of experience, for example ADHD and cannabis use (Mitchell et al., 2016). Miller and Fleischmann’s (2010) report based upon their presentation at a conference was not available to access, however this was later published in the journal article authored Fleischmann and Miller (2012), which has been included in this review. See Figure 1 for the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) diagram (Page et al., 2021) which demonstrates the review process.

Figure 1

Systematic literature search process represented in PRISMA diagram (Page et al., 2021)



Approaches to synthesis

All eleven studies were included in the synthesis, in part due to the limited amount of research relevant to the review questions. All studies produced thematic results, using different qualitative design and analysis methods. A thematic synthesis was conducted to bring together and integrate these themes (Thomas & Harden, 2008). This was chosen following the recommendations by Flemming et al. (2019) and Booth et al. (2018) for choosing qualitative synthesis methods. For the current review, thematic synthesis was chosen due to: its ability to be structured to answer review questions directly; the lack of a pre-existing theory required for framework synthesis; and as the data appeared through preliminary reading through of the eleven studies to have generated a mix of both ‘thin’ descriptive data as well as ‘thicker’ in-depth analytic themes. Thematic synthesis is also indicated by the resources and purposes of the review; its inductive coding capability to produce explanatory hypotheses. Thematic synthesis was completed using the three stages they recommended: inductive or ‘close’ coding of the reports’ texts; development of descriptive themes by grouping codes into a hierarchical tree structure; and generation of inferred explanations or hypotheses to answer the current review’s questions.

Other synthesis approaches, such as meta-ethnography or narrative synthesis, were not considered to be appropriate for this review. Whilst it has the capacity to develop new theoretical insights, meta-ethnography may be better aligned to studies that share a high degree of conceptual intersection and similar methodologies, both which may not align with the diverse qualitative designs included in these studies (Noblit & Hare, 1988). Narrative synthesis, another common approach, focuses on organising synthesis into descriptive narratives and may lack depth of inference provided by thematic synthesis (Popay et al., 2006). Given the timeframe of this major research project, thematic synthesis appeared the most appropriate approach for synthesising the varied research data in this review.

Epistemological position and reflexivity

This thematic synthesis adopted a critical realist approach, which assumes that an external reality exists, but our understanding of it is shaped by social, cultural, and discursive processes. This lens supports exploration of subjective online content and the mechanisms that shape how ADHD is discussed, such as stigma, diagnosis, and algorithmic visibility. As Barnett-Page and Thomas (2009) note, thematic synthesis generates interpretive findings while assuming a degree of shared reality, with the aim of informing policy and practice.

The author, a clinician without a personal ADHD diagnosis but with close professional and personal proximity to the topic, has observed both positive impacts of ADHD identification and challenges related to stigma and questions of selfhood, particularly when medication alters mood or executive function. These experiences influenced interpretations of participant narratives. Reflexivity was supported through engagement with critical literature on ADHD's conceptualisation and potential overdiagnosis (Moncrieff et al., 2014; Whiteley, 2014; Carson et al., 2023), as well as through supervisory discussions. These processes informed an iterative analytical approach, in which themes were revisited and refined using ongoing critical reflection.

Results

Data were extracted from the studies. Please see Table 3 for a summary of each study’s aims, design, method of recruitment, data analysis, and main findings relevant to the current review questions. Additionally information was extracted regarding the author’s positionality, including whether they self-disclose their own personal relationships to ADHD or neurodivergence, and frameworks they have used to approach their study design and data analysis.

Table 3

Study characteristics

Paper Author(s), Year and Positioning	**Type of publication**	**Design. Sample type, size and sampling method**	**Demographics including ADHD status**	**Study objective**	**Approach to analysis**	**Main finding and themes**
1. Comstock, (2015). Does not declare if they are ADHD/ neurodivergent. Uses Foucauldian perspective on biopower and medicalized subject	Peer reviewed journal	Cross-section netnography. Forum posts on ADHDnews.com and ADDForums.com. One thousand posts read from ADHDnews.com from 2005-2007 (author's approximation); one hundred randomly selected fragments closely analysed. Process repeated with ADDForums.com. All accounts chosen were first-person, and reasonably believed to have come from an adult.	Gender, age and ethnicity unavailable. Included posts from people awaiting diagnosis, and who have received diagnosis. Findings not split by those who have received diagnosis and self-identified ADHD. Did not aim to/was not possible to 'confirm' ADHD diagnosis status.	"…to contribute to the growing body of research that explores the role of the individual in both embracing and resisting medical discourses and techniques in constructing identities."	First stage of 1000 posts: Strauss and Corbin (1998) grounded theory, modified for discourse analysis. Critical discourse analysis for 100 closely analysed fragments.	ADHDNews.com posters generally more positive and likely to identify with ADHD than ADDforums.com. Posts reflect desire to change the self through self-management and medication to realise self-actualisation and productivity, and not explicit verbalisation of social norms. Tension between the 'observing self' that knows of the ADHD and potential for self-actualisation, and the other self (brain, body or mind) which is disorganised and unobservant. ADHD diagnosis provides meaning and bridging of the two selves into a new identity (first evident in the common theme of "I've always known something was wrong"). Taking ADHD medication for the first time as a significant act which provides clarity. An ethical or self-investing act in their "true organised" identity. Medication provides managerial control over the self, and also becomes a daily ritual to affirm ADHD identity. Taking medication entails investments in time, memory, purpose and money – the domains described by posters as the essential ADHD. Provides meaning to their difficulties channelling their energy and motivations. Look to biological explanations and treatment as cause and solution for difficulties with self-management and productivity. Less focus upon

						on physical effects of medication. Some concern about side-effects and search for correct medication.
2. Ginapp et al., (2023). First author is medical student diagnosed with ADHD. Second author is medical student with several family members with ADHD. Framework or ontological perspective not explicitly stated.	Peer reviewed journal	Nine semi-structured focus groups held over Zoom, with 3 to 6 participants per group. N = 43. Recruited from online communities: Facebook groups (72%), sub-Reddits (5%), and the Children and Adults with ADD (CHADD) advocacy group website (23%). Inclusion criteria of age 18-35 years inclusive, have received diagnosis from clinician, and score equal to or greater than 23 out of 30 on the Adult ADHD Self-Report Scale.	Median age 29 years. Gender and ethnicity not reported by frequency, but stated “…our sample of mostly white women”. 86% participants from North America. Aimed to ‘verify’ diagnoses by prescription or documentation. 63% of participants provided full details for data sharing; all of these diagnoses were confirmed. Diagnoses by ADHD subtype: Inattentive 42% Combined 28% Hyperactive/impulsive 9% Remaining did not know subtype or diagnosis preceded introduction of subtype classification.	“…to better understand how young adults with ADHD interpret their experiences interacting with society, managing interpersonal relationships, and building community. It also sought to understand potential benefits and drawbacks of online communities for young adults with ADHD”	Interpretive phenomenological analysis (IPA)	93 percent of participants were involved with ADHD communities on social media, most commonly Facebook (74%), followed by TikTok (40%), Instagram (33%), Reddit (28%), and Twitter (14%). Supports embracing their ADHD identities. Shared content viewed to be more relatable and accessible, with day-to-day examples compared to clinical explanations. Sharing of concepts like “rejection sensitivity dysphoria” “executive dysfunction” and “neurodivergent”. Opportunities to build communities and share coping strategies. Many felt strategies shared were more helpful than those shared by clinicians. Concerns about accuracy of information, including attributing common human experiences to ADHD. Not wanting to share personal information, or fear of rejection. Not feeling they fit in the communities. Overwhelm from messages and time spent on communication.
3. Thelwall et al., (2020). Author does not declare if they are ADHD/neurodivergent.	Peer reviewed journal	Tweets on Twitter.com matching “my ADHD” (n=58,893) were analysed. 99 other conditions (n=1,341,442) such	Gender, age and ethnicity unavailable. ADHD status not possible to confirm. “My ADHD” chosen as tweet string due to this accessing first-person	1. What are the main themes of personal ADHD discussions on Twitter? 2. How are ADHD discussions different from other	Analysis 1: Thematic analysis. Analysis 2: word association thematic analysis	Analysis 1 themes in order of most to least frequent: (1) My ADHD feels like; sharing experiences, emotions, and triggers of daily life. Mostly had a negative tone. Positive tweets often differentiated or tried to detach from ADHD, which acts

Framework or ontological perspective not explicitly stated.		as “my depression”, “my doctor”, “my allergies”, “my flu”, “my acne”, “my cancer” were also gathered. Two analyses conducted. Analysis 1: thematic analysis of 200 randomly selected “my ADHD” tweets. Analysis 2: comparing differences in tweets about “my ADHD” compared to other “my condition” related tweets.	accounts of ADHD, though authors highlight that ADHD status is implicit. I.e. sample likely includes diagnosed and self-identified ADHD.	medical discussions on Twitter?		as a separate entity e.g. “my ADHD will always say NO to any kind of work”. (2) Managing my ADHD. This included in order of most to least frequent: sharing coping strategies; asking questions or sharing experiences about medication use, particularly effectiveness and side-effects; humour-based coping; having received or still seeking a diagnosis including being stuck on waitlists. (3) Understanding, Support & Awareness of ADHD; this was mostly sharing their experiences of stigma about their ADHD behaviours or widely held beliefs, from family, friends, education and/or workplaces. Highlighting the need for others to educate people about ADHD, or how to support others with ADHD e.g. children. (4) Embracing my ADHD. This was positive tweets about ADHD as a strength or superpower, or acceptance of ADHD as part of everyday life. Tweets mentioning “neurodiversity” described positive identity formulation. Analysis 2: Themes which were most represented in “my ADHD tweets” compared to other “my…” health condition tweets were: medication; focus including hyperfocus and distraction; fidgeting; “accommodations” as the need for them, typically from education or work; desire or need for a diagnosis, “my ADHD brain” to distance the speaker from their actions or to provide explanations for their actions; “neurodivergent” as a positive term; “blame and causation; and complex self-structures and the use of “self” which represented the increased need to provide explanations or justifications of their ADHD

						symptoms or behaviours, compared to other physical health conditions or experiences.
4. Fleischmann, A. and Fleischmann, R. (2012). A. Fleischmann is an academician. R. Fleischmann is a 26-year-old medical student diagnosed with ADHD at 24. Framework or ontological perspective not explicitly stated.	Peer reviewed journal	N = 71 first-person narratives, self-published on the Internet as biographies or on websites dedicated to living with ADHD (websites not specified). Adults who received a diagnosis of ADHD after adolescence. Those that clearly referred to self-identified ADHD were excluded. Main diagnosis and main problem in their narrative, as stated by the narrator, was ADHD. Narratives were assessed for face validity by three external referees – adults with diagnosed ADHD.	Ages not reported, though all narratives shared were reasonably assumed to come from adults. Gender and ethnicity were not commented upon.	No aims or objectives explicitly stated. "…we investigate how adults with ADHD view the course of their lives. Given our interest in the importance of an ADHD diagnosis for coping processes in adulthood, we focus on stories of persons who were diagnosed after high school."	Strauss and Corbin (1990) Grounded theory. To further test validity, 41 stories were additionally analysed through Labov's (1982) textural-analysis method. Primary findings were mutually consistent.	Some narratives described that after receiving their diagnosis, they consulted websites and books for information and others' autobiographical accounts. These discoveries led to the realisation that their difficulties originated in ADHD, not character flaws. Consequently, they began to view their present and future in a more positive light, with more comprehensibility, manageability, predictability and meaning to their lives. Release of guilt and shame. The narratives shared seemed to serve as a "road to empowerment" for the narrator and others. The narratives analysed in this article reveal that some adults with ADHD took an additional step in the process of coping with their condition by documenting and sharing their life experiences as a way of educating, inspiring, and assisting others with ADHD in their coping processes.
5. Fleischmann, A. & Miller (2012). Authors do not declare whether they are	Peer reviewed journal	N = 40 adults diagnosed with ADHD, who had shared their narratives online. Sample is same as that in above study.	As above.	No aims or objectives explicitly stated. "Recently, adults with ADHD have been publishing online narratives	Labov's (1982) textural-analysis method.	Similar findings as above. In addition, reported findings upon the components and nature of the life stories and how they were shared: Purpose of not only sharing information like you would in a "file or a program", but the feeling of not being alone in one's experience. Sense of shared emotions and communication.

ADHD/neurodivergent. See Fleischmann, A. above. Framework or ontological perspective not explicitly stated.		Sample collected at end of 2004, then additional search from August 2006 to February 2007. This study shared the details of the 15 websites used including livingwithadd.com, adders.org, brainblogger.com, addcoach4u.com and additudemag.com Three sites were .il Israel sites, translated from Hebrew.		that document ways in which they cope… Despite the intensive research regarding ADHD in adults, it is still necessary to explore how they personally understand the ways by which they have come to manage… we reveal the processes that characterize how adults with ADHD cope in their daily lives and how their diagnosis in adulthood was an influential turning point for them.		They hoped others would find their narratives comforting too. Authors offered the option of contacting them. Twelve of 40 narratives invited the reader to use their story and information available on the website, to develop their own strategies and to come to terms with their ADHD identity. Some stated they were inspired to share their narrative, after being helped by others. Potential sense of reframing their own narratives through writing. Shared or collective empowerment.
6. Winter et al. (2015). Discursive approach within a broad feminist trajectory. That the increase in ADHD diagnoses for women is "… ascribed to situations in which women fail to attain to normative societal expectations…medicalisation of	Peer reviewed journal	Searches on YouTube for "ADHD women" over the period of September 2011-July 2012. The analysis of five videos were reported, that provided either first-person testimony or in one video an interview by a news reporter of of three women diagnosed with ADHD.	The five videos from: Female college student (younger than 18 years). Woman with ADHD who, as part of a two-part documentary for a university course, interviews other women with ADHD and a medical expert. Three women with a diagnosis of ADHD are interviewed by a news reporter.	No aims or objectives explicitly stated. "We locate our discourse analytical frame within a broad feminist trajectory…This enables us to take a critical stance towards psychiatric Gendered Rhetoric of the ADHD Woman in relation to ADHD whereby we can identify and	The framework and techniques of discursive psychology with principles of critical discourse analysis (CDA) (Fairclough1995)." "…critical discourse analysis aims to make transparent the relationships between discourse, social	Entitlement and Credibility: The rhetoric surrounding ADHD in women often involves appeals to authority, such as doctors recommending specific treatments, to establish credibility and reinforce claims. Medicalization and Disability: The discourse around ADHD in women often frames it within the realm of physical health, leading to assumptions about lack of agency and moral judgment. Questioning the ADHD diagnosis is equated with denying disability and being judgmental. Fulfilling Expectations: Women in the study either embrace or seek ADHD diagnosis as a means of improving their lives, with a focus on

normal behaviour variation" Authors do not share their own ADHD/neurodivergent status.			Narrator describes herself as a "sufferer of ADHD", and her life experiences including prescribed Ritalin and Adderall. Narrator as a "doctor" who was diagnosed with ADHD. Life experiences and positive effect of Adderall. Ages and ethnicity are not reported.	problematise the normative, and often psychopathological constructions of gender in mainstream psychiatric diagnosis.	practices, and social structures.	the aspirational qualities of diagnosis and treatment. The rhetoric often contrasts life with and without diagnosis to emphasize the benefits. Narratives of Struggle and Transformation: Personal stories of women struggling with daily tasks and feeling overwhelmed before diagnosis are used to illustrate the transformative power of ADHD diagnosis and treatment. The narrative shifts from hardship to success post-diagnosis, reflecting a medicalization of underperformance.
7. van Berkel et al. (2015). Authors do not share their own ADHD/neurodivergent status. Framework or ontological perspective not explicitly stated.	Peer reviewed journal	Analysed 5532 posts on Dutch online message boards related to ADHD, amyotrophic lateral sclerosis (ALS) and diabetes (type 1 and 2). 2517 posts on ADHD were analysed. Three message boards were used for ADHD. Fok (general message board aimed at young people), Viva (general message board aimed at adult women) and Babybrabbel (for women who are pregnant or recently had a baby).	Ages and ethnicity were not reported.	"…examine whether empowerment processes occur on message boards discussing medicines used to treat three chronic diseases: diabetes (Type 1 and 2), ADHD and ALS. Because information plays an important role in both empowerment and successful self-management, we also evaluated the quality of information about medicine use that is exchanged on online message boards between patients suffering	Deductive thematic analysis based on pre-existing categories around empowerment processes and quality of information exchanged	Empowerment Processes: Discussions on ADHD in online forums involve various empowerment processes such as information sharing, personal experiences, empathy or support, and requesting information or advice. However empowerment processes were greater for ALS and diabetes. This could be associated with a lot of discussions about the validity of ADHD as a diagnosis and use of stimulant medication. Medicine-related Discussions: Participants in ADHD-related discussions seek information about how to obtain medications, asking, improvements, side effects, and behavioural coping strategies especially at work. Access to Experimental Medicines: In the context of ADHD, there is a discussion about obtaining access to experimental medicines or the existence of non-pharmaceutical alternatives, indicating a proactive approach and sense of empowerment.

				from these diseases.”		Information shared was largely correct, or deemed by the authors to be “largely harmless”. Participants also corrected previously posted incorrect information, and referred people to a healthcare professional following a request for medical advice.
8. Versteeg & te Molder (2019). Authors do not share their own ADHD/neurodivergent status. Framework or ontological perspective not explicitly stated.	Peer reviewed journal	Data was selected from the above van Berkel et al. (2015) study of posts on Dutch message boards about ADHD, ALS and diabetes (type 1 and 2). Used 77 message board threads of conversation; 32 were about ADHD. The length of threads varied from less than 10 to more than 300 posts.	Ages and ethnicity were not reported.	Not explicitly stated. “…focuses on the way in which various patient groups take responsibility for their own health in real-life online interactions; in particular, how they navigate between certified expert advice and individual patient experiences”.	Discursive psychological methodology	Users with ADHD emphasize the importance of acquiring an official diagnosis from a clinician, typically a psychiatrist. They distinguish between those who receive a diagnosis of ADHD and those who exhibit ADHD-like symptoms but “do not have ADHD”. Users seem to protect the validity of ADHD through collective enforcement of a boundary between “real” ADHD or not. This is evident in their reactions to new posters querying their symptoms, especially if they describe few symptoms. These posts are quite negative in tone. Users with ADHD hold each other accountable for the validity of ADHD, emphasizing the epistemic authority of certified experts as the only ones able to diagnose “real” ADHD. They stress the seriousness of ADHD and the difficulties it can cause them in day-to-day life. Collective Engagement in Boundary Work: Participants engage in boundary work to differentiate between individuals genuinely suffering from ADHD and those perceived to be adopting the disorder as a fashionable label. Users treat a diagnosis of ADHD as empowering, as it provides an explanation for their difficulties. Maintaining the exclusivity of the ADHD diagnosis is crucial for patients to view ADHD as a "doctorable" problem worthy of medical attention and treatment.

9. Palonis (2021) Author does not share their own ADHD/neurodivergent status. Framework or ontological perspective not explicitly stated.	Masters Thesis	A total of 1,722,769 Reddit.com comments from the subreddits r/Blind, r/ADHD, and r/disability were collected from January 2015 to December 2019. After data cleaning, 38,441 comments related to ADHD were analysed.	Age and ethnicity was not reported. School-related words were mentioned in some comments, though the vast majority were around “job” “work” or “task”. Therefore the majority of users can be reasonably assumed to be adults.	RQ1:What topics are discussed on r/Blind, r/disability, and r/ADHD? RQ2:Which topics receive the most interaction over time per subreddit?	Software technique of Latent Dirichlet Allocation (LDA) to extract topics. Features are then put into key phrase category taxonomy, with the topics qualitatively discussed.	The most common topic on r/ADHD was sharing their experiences of navigating social situations including rejection sensitivity, difficulties experiencing criticism, and difficulties controlling intense emotions. This topic was closely followed by discussions of the medical system, diagnosis and medication. The third most common topic was themes around disability, and then fourth most common was sharing of strategies for organisation and routines. All subreddits had discussions around societal understandings of disability. On r/ADHD this discussion often took the form of anger or frustration at societal misunderstandings of ADHD or jokes about ADHD. Able-bodied people’s reactions to accommodations such as that they are ”lucky” or ”special” to have ADHD and “special treatment”. This results in guilt or refusing to seek accommodations to being perceived differently. Support and “commiseration” were most common in the r/ADHD subreddit. Posts did not typically ask for advice, support or encouragement, but seemed to serve as a space to vent emotions.
10. Steinbeck (2024). Author does not share their own ADHD/neurodivergent status. Framework or ontological	Bachelors thesis	Ninety-three Instagram posts from 1st August 2023 to 2nd November 2023, by women (age 18 and over). Accessed through search using the tags #ADHDwomen and #ADHDawareness.	Age and ethnicity were not reported.	“How can women's digital storytelling within Instagram actively contribute to reducing the stigma associated with ADHD?”	Reflexive Thematic Analysis (Braun and Clarke, 2019, as cited by Steinbeck, 2024)	Empowerment was an overarching and main theme. Users shared on Instagram to raise awareness and understanding of ADHD (including challenging misconceptions that it is a childhood condition), share challenges (particularly around executive functioning) and also support. Sharing of personal experiences and encouraging use of strategies and peer support seemed to facilitate acceptance of identity and personal growth.

perspective not explicitly stated.		Content available in English was used.				The second most frequent theme was emotional experiences – typically negative – as well as emotion regulation strategies and sharing examples of dysregulation.
11. Eagle and Ringland (2023). Critical disability perspective used that “privileges the lived experiences of disabled and neurodivergent individuals.” “Some of the authors identify as neurodivergent and/or disabled… our goal is not to speak for our participants but to broadcast their experiences and consolidate themes in order to better support neurodivergent communities in the future”.	Conference article	Ethnographic methods for ‘unbound’ online communities used; ‘unbound’ defined as social media spaces where users come across the content organically unlike domain or purpose specific spaces e.g. content appears due to algorithms, rather than the users intention to join a group or forum specifically for one topic. Also without moderation, and users can be anonymous. Author immersion in TikTok, Twitter and Instagram content in ADHD communities. Data was collected over 15-20 hours per week for 18 months, from posts between 2020 to 2022. Thematic saturation of data reached; no definite data source quantity provided.	Age and ethnicity were not reported. Content available in English was used.	How does the ADHD community leverage existing social media platforms to provide support previously contained within domain-specific [unbound] online health communities?	Techniques from Charmaz’s (2006) grounded theory – iterative and inductive process of data familiarisation and coding. Initial themes, category consolidation, and relationships between codes and concepts. Memo taking.	Main themes included discovery of ADHD and shared experiences of navigating the different stages of seeking a diagnosis or not. Shared support around hesitancy to mention learning from social media about ADHD to clinicians due to being dismissed. Sharing of advice and supportive communities amongst a ‘neurotypical world’. Theme of validation, acceptance and empowerment. Included parents who realised their own ADHD whilst completing the diagnostic process for their child. There was “debunking” by users of misinformation about ADHD, such as comments and video responses to posts which were inaccurate such as “blinking to the beat of a certain song”, or too generic ‘like “trouble focussing”. Shared experiences, including difficult topics such as fear of being an “imposter” or “lazy”, pre and post-diagnosis. Also normalising experiences that can be stigmatising such as difficulty managing daily hygiene.

Overview of studies

The eleven reports that were analysed were published from 2012-2024, majority of these being published within the past decade (except for Fleischmann & Fleischmann, 2012; Fleischmann & Miller, 2012). Only one study involved direct involvement with participants using focus groups (Ginapp et al., 2023). The ten remaining studies qualitatively analysed social media or online message board posts. There were two instances where two studies analysed the same data set using a different analysis method: Fleischmann and Fleischmann (2012); and Fleischmann and Miller (2012); van Berkel et al. (2015); and Versteeg and te Molder (2019).

The majority of studies analysed data from websites that were not country specific, but are engaged with in English. Steinbeck (2024) and Eagle and Ringland (2023) analysed data from websites such as Instagram (and the latter authors also analysed TikTok and Twitter), however they excluded posts that were not available in English. The Fleischmann and Fleischmann (2012), and Fleischmann and Miller (2012) data set included three Israeli websites in Hebrew. The van Berkel et al. (2015) and Versteeg and te Molder (2019) datasets used Dutch message boards.

Quality Assessment

Study quality for each of the eleven studies was assessed using the Critical Appraisal Skills Programme tool (CASP, 2018) for qualitative research. The tool addresses questions such as the validity of the study design, ethics and analysis of results, and the value of the research to contribute to current practice, policy or the research literature. See Table 4 for a summary.

Table 4

Summary of quality appraisal using the CASP (2018) checklist tool

Paper	Clear aims?	Qualitative methodology appropriate?	Research design appropriate?	Recruitment strategy appropriate?	Data collection appropriate?	Relationships considered?	Ethical issues considered?	Data analysis rigorous?	Clear findings?	Valuable contributions?
Comstock, (2015)	Yes	Yes	Yes	Yes	Yes	Partial	Partial	Yes	Yes	Yes
Ginapp et al.,(2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Thelwall et al., (2020)	Yes	Yes	Yes	Yes	Partial	No	Yes	Yes	Yes	Yes
Fleischmann and Fleischmann, (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Fleischmann and Miller, (2012)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Winter et al., (2015)	Partial	Yes	Yes	Yes	Partial	Partial	No or not explicitly discussed	Yes	Yes	Yes
Van Berkel et al., (2015)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes

Versteeg and te Molder, (2019)	Partial	Yes	Yes	Yes	Yes	No	No, or not explicitly discussed	Yes	Yes	Yes
Palonis, (2021)	Yes	Partial	Yes	Yes	Yes	No	No, or not explicitly discussed	Yes	Yes	Partial
Steinbeck, (2024)	Yes	Yes	Yes	Yes	Partial	No	Yes	Yes	Yes	Yes
Eagle and Ringland, (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Partial	Yes	Yes

Aims and method

Overall the selected studies set out their research aims clearly, and the rationale for qualitative methodology was provided. Versteeg and te Molder (2019) did not explicitly provide research questions or aims, though they stated their study "focuses on the ways in which various patient groups take responsibility for their own health in real-life online interactions; in particular, how they navigate between certified expert advice and individual patient experiences". Winters et al. (2015) also did not explicitly provide aims or research questions; instead, they described their study as located within a "discourse analytical framework within a broad feminist trajectory. This enables us to take a critical stance towards psychiatric Gender Rhetoric of the ADHD Woman in relation to ADHD whereby we can identify and problematise the normative, and often psychopathological constructions of gender in mainstream gender services".

The studies showed heterogeneity in their aims and approaches. Five studies explored the use social media and online communities by people with ADHD to engage in particular psychological processes: evolution of narrative or identity over time (Fleischmann & Fleischmann, 2012); processes of managing and coping, particularly after diagnosis (Fleischmann & Miller, 2012); empowerment processes (van Berkel et al., 2015); responsibility taking for health management between 'experts' and patients (Versteeg & te Molder, 2019); the reduction of stigma about ADHD (Steinbeck, 2024). Two studies explored the topics discussed in ADHD spaces online; Thelwall et al. (2020) and Palonis (2021). Ginapp et al. (2023) explored how young adults interpret their experiences with ADHD with relationship building and being part of wider society, with an additional aim of exploring directly with research participants what they perceive the benefits and potential drawbacks of online communities for ADHD to be. Winter et al. (2015) and Steinbeck (2024) explored the use of social media by women with ADHD. Comstock (2015) aimed to explore the embrace and resistance of medical discourses in constructing identity in ADHD.

Eagle and Ringland (2023) aimed to compare the use of "unbound" online ADHD communities for support, where previous research such as Thelwall et al. (2020) and Palonis (2021) have explored within "bound" online communities. "Unbound" online communities are defined within Eagle and Ringland's (2023) report as communities where users come across the content organically through algorithm recommendations, compared to spaces where users have intentionally searched for a particular message board based upon a topic, or to join a particular group (such as Facebook with topic groups). They also define these unbound communities as without moderation (unlike message boards or forums including Reddit). Four studies compared the content and themes of online posts by people with ADHD to other medical conditions (Thelwall et al., 2020; van Berkel et al., 2015; Versteeg & te Molder, 2019) or disability (Palonis, 2021).

Frameworks

Similarly to the research aims and designs, the eleven reports showed heterogeneity in their frameworks Winter et al. (2015) and Steinbeck (2024) explored the use of social media by women with ADHD, however the former aimed to identify normative and "often psychopathological" constructions of gender in mainstream psychiatric diagnoses through a "broad feminist trajectory"; the latter aimed to explore the resistance of discrimination and stigma in ADHD, and particularly so in women who have often not received a diagnosis or explanation for their experiences. Comstock's (2015) discourse analysis took influence from Foucauldian perspective on biopower and the medicalised subject. No study explicitly stated epistemological or ontological perspectives. Studies were also limited in stating their positionality with regards to ADHD such as whether they have personal or close lived experience with ADHD, or explicit discussion about their clinical experiences or perspectives with working with people with ADHD; Ginapp et al. (2023), Fleischmann and Fleischmann (2012) and Eagle and Ringland (2023) were the only reports to provide statements of their positionality.

Research design and data analysis

As above, ten of the eleven studies sourced and analysed data from social media and online message boards or forums. One only, Ginapp et al. (2023), recruited participants and asked them about their experiences of online communities.

The eleven studies used a variety of different qualitative analysis methods. There was a relatively equal mix of studies using discourse analysis, grounded theory (using different influencing frameworks or perspectives) and thematic analysis.

Sampling and data collection

The collecting of the data samples from online posts were varied, with most (seven) studies manually collecting data online, and two using automated data collection methods (Palonis, 2021; Thelwall et al., 2020). The latter two were able to analyse vast amounts of data (38,441 and 58,893 tweets respectively), though Thelwall et al. (2020) ultimately thematically analysed 200 randomly selected posts. There was also significant variation in the use of different means or search strategies to obtain data online. Some of the reports were limited in their explanation and justification of these methods. Thelwell et al. (2020) acknowledged and discussed the benefits and limitations of the search strategy of tweets for “my ADHD”. Winter et al. (2015) closely analysed five YouTube videos where at least one person who has received a diagnosis of ADHD discusses their experiences in a variety of different approaches (such as interview as part of a documentary for a university assignment, from an individual student's account, or interviews with medical 'experts') however the rationale for the selection of these specific videos was limited.

Ethical issues or discussion

Reports by Winter et al. (2015), Versteeg and te Molder (2019) and Palonis (2021) did not describe any ethical approval or considerations; it is assumed this is due to the nature of their design which used data freely available from the internet and without using direct quotes or identifying information in their reporting. However there were other studies with similar designs such as Fleischmann and Fleischmann (2012) and Eagle and Ringland (2023), who provided additional discussion around ethical considerations to using openly available internet data even if ethical approval was not required.

Findings

All reports provided a clear statement of findings, organised into themes. The majority provided a high quality discussion of the themes generated and how this relates to the research literature or implications for future research; Palonis's (2021) theme discussion seemed to generate "thin" or descriptive data, with limited interpretation by the author.

Value of research

Almost all the reports discussed to some extent the value of the research in terms of their contribution to understandings about how individuals and communities understand ADHD, how this may contrast or conflict with "professional" perspectives, and individual processes described above in *Aims and method.* Authors highlighted the implications for how clinicians and researchers can promote and facilitate shared and evolving understandings, broaden research criteria, and redistribute clinical power. The reports were limited in being able to provide specific clinical or policy recommendations.

General critique

As a body of literature, overall study quality was considered to be medium quality. The review highlights the limited range of studies that have explored the current research review question, and the need to explore grey literature. However, the analysis of the online communities in the review studies can be considered to have ecological validity compared to studies such as Ginapp et al’s (2023) focus groups with participants where reporting of the use of online communities may be subject to reporting inaccuracies, as well as the impact of self-selecting into a study that explores the use of these online spaces. Studies appeared to draw upon internationally accessed online communities and narratives, however a significant critique of the reports in this review is the inability to ascertain the demographics of the users. The websites included also appeared to be (mostly) accessed by users in Western countries, or studies excluded posts which were not available to them in English.

Thematic synthesis

Three broad analytical themes were generated to answer the review questions. Six subthemes provide additional exploration of processes underlying the use of and tensions within social media and online communities. See Table 5 for themes.

Table 5

Themes and subthemes identified across studies

Theme	Subtheme
1. Sense of ADHD community	Shared experience, learning, and language Who is trusted to hold expertise and validity of the concept of ADHD? Enforcement of accuracy, exclusivity and boundaries
2. Identity negotiation and development	Empowerment through narrative development and sharing Role of the self-observer, and experience of being the 'observed'
3. Navigating the 'outside' world or society	Where does cause and solution of difficulties lie? Drive for productivity, self-investment and self-actualisation

The processes of ADHD communities online

Shared experience, learning, and language

All studies described experiences of sharing experiences and advice or coping strategies. There is a process of potentially learning or coming across narratives about ADHD for the first time through algorithms (Ginapp et al., 2023; Eagle & Ringland, 2023) that served as the first point of self-understanding. These narratives and the sharing of day-to-day experiences promote self-understanding in a different manner or process than the knowledge they already held about ADHD as a diagnosis and its symptoms. Online community, knowledge and personal accounts were then actively consulted (Fleischmann & Fleischmann, 2012; Fleischmann & Miller, 2012).

Narratives served to provide a sense of shared experience and belonging. The sharing of coping strategies, information about how to seek or navigate the diagnostic process (and whether this is desired for each individual), and information about medication promoted empowerment. Fleischmann and Miller (2012) noted the occurrence of users going on to share their own narratives and advice, in the hopes this would help others as they had themselves learned and grown from their search and exposure online to others' narratives.

The learning of and shared use of terms such as "hyperfocus" and "rejection sensitivity dysphoria", assisted with giving name to experiences and enabling further understanding. The trust, belonging and shared language within these communities may also serve to entrench a sense that one turns to these spaces, over seeking support from clinicians. This is suggested by one of the participants in Ginapp et al's (2023) study that "that's the only place where you feel understood. I feel like when you have ADHD that's the only place you can relate to, you're almost in tears sometimes. So, the online community is very important to me, that's where I feel normal, that's where I feel like I belong". This leads to tensions about where expertise about ADHD is held within online communities.

Who is trusted to hold expertise and validity of the concept of ADHD?

All studies included themes about the request of information about ADHD, including diagnosis and medication. This medical discourse seemed to represent process within the community to enforce and enact boundaries between the diagnosis of ADHD, which preserves the acceptability of things such as each individual's choice to take medication or to ask for accommodations within society such as from employers or educators. Versteeg and te Molder (2019) described themes that the online ADHD community held itself accountable as a collective to maintain the validity of ADHD, though the epistemic authority was deferred or deemed to be held by the “certified experts” (also described extensively by Winter et al., 2015).

Enforcement of accuracy, exclusivity and boundaries

Public discourse and research literature has explored the potential lack of accuracy and quality in information shared and discussions about ADHD online (Yeung et al., 2022). However in the current review, there were several studies which noted information discussed appeared mostly accurate or “largely harmless” (van Berkel et al., 2015). The community was observed to also manage or actively “debunk” inaccurate information (Versteeg & te Molder, 2019; Eagle & Ringland, 2023). There was also wider use of online communication and narratives to actively challenge misinformation and stigma held in wider society (Steinbeck, 2024).

Identity negotiation and development

Empowerment through narrative development and sharing

All studies described in all or some of the samples they studied, a sense of self-growth, and empowerment. Winter et al. (2015) observe that the sharing of narratives of “hardship” prior to diagnosis, the “aspirational qualities of diagnosis and treatment”, and the contrasting of life before and after diagnosis serve to, in their view, promote the validity and desirability of ADHD as a diagnosis. They suggest that this narrative reflects a “consumer” approach to the “medicalisation of underperformance” within a “late capitalist society”; this is discussed further in the subtheme *Where does cause and solution of difficulties lie?.*

In Ginapp et al’s (2023) study, the learning of and use of terms such as “neurodivergent” assisted with a sense of being able to claim their identity with ADHD without a sense of being othered. A participant described it as “I don’t have to say weird, I don’t have to say unique, I don’t have to say different, I can just say neurodivergent, and I feel really proud of that statement". Steinbeck (2024) and Winter et al. (2015) studied the use of sharing information and narratives online as means to challenge stigma about ADHD, and this can also be seen as a form of personal empowerment.

Role of the self-observer, and experience of being the 'observed'

ADHD was described with some aspects of internalisation, and other aspects of separation or distancing from ADHD. Thelwall et al. (2020) described a theme of tweets with a positive tone often differentiated or detached the self from the ADHD, for example "my ADHD will always say NO to any kind of work" (ibid, p. 19). Comstock (2015) interpreted forum posts as enacting the tension between the "observing self" that recognises (or has learned through being informed by others) the experiences associated with ADHD, and the "other self" where the experiences originate (typically these were located within the brain, body or the mind). This theme links to the subtheme *where does cause and solution of difficulties lie?*.

All studies reported to varying extents, themes of the ADHD experience where individuals have been blamed for their behaviour and lack of "effort" in education or employment. This seems to have resulted in experiences of shame and perhaps anticipating future criticism and observations from others. Thelwell et al. (2020) noted a pattern of complex sentence structures in tweets about ADHD which seemed to serve the function of the need to provide explanation and justification of their behaviours, compared to tweets about other health conditions. Paradoxically, Palonis (2021) described the theme of ADHD community frustration at societal misunderstandings and interpretations of being "lucky" or "special" to have ADHD to receive "special treatment" accommodations. People in ADHD communities appear to undergo a process of being both blamed for their symptoms and potentially impaired productivity (linked to the theme *Drive for productivity, self-investment and self-actualisation*), and also for accessing resources such as medication and accommodations that would enable them to achieve this state of productivity.

Navigating the 'outside' world or society

Where does cause and solution of difficulties lie?

Linked to the subtheme above *Enforcement of accuracy, exclusivity and boundaries*, there were tensions between understandings of ADHD as a biological or medical experience with interventions predominantly focussed upon medication, or under the paradigm of neurodiversity and difficulties being mostly due to societal barriers, expectations for productivity within neoliberal systems, and misunderstandings and stigma.

As described above, the narratives online about ADHD demonstrate the difficulty people with ADHD navigate of both being blamed for their difficulties with work, education or interpersonally, and also feeling misunderstood and shamed for "special treatment" through diagnosis, medication and accommodations (Palonis, 2021). Communication and narratives that embraced neurodiversity or embracing mind-body dualism by distancing from ADHD through its location within the brain and body, seemed to serve to protect the individual from the tension of being in both of these positions.

Drive for productivity, self-investment and self-actualisation

All studies described to some extent, accounts of difficulties with education and employment. The use of medication and embedding personal management and coping strategies seemed to serve to promote self-actualisation and the sense of being a productive member of society. Comstock (2015) discussed that this drive seemed to serve on an individualised level rather than due to a need to conform with social norms. This may link to the subtheme *Where does cause and solution of difficulties lie?*.

Discussion

This systematic narrative review sought to establish critical evaluation relating to the previous two questions regarding: (1) how adults with ADHD access social media such as online platforms and online communities; and (2) what the shared experiences of ADHD are, including expressed tensions or disagreements online, and resolutions to these in the formation and synthesising of ADHD knowledges. The review's search process, outlined in the PRISMA diagram above, returned 11 studies. There were difficulties synthesising findings from the studies. In some cases these were due to variability in design and analytical approaches deployed to study online narratives. For example, Winter et al. (2015) uses a feminist, discursive framework to analyse YouTube videos, while Versteeg and te Molder (2019) focus on a style of discourse analysis in online forums. The ability to draw consistent conclusions across studies also posed a challenge. Notably there were also no cultural and linguistical differences as all studies deployed English-speaking online platforms. It potentially restricts cultural nuances and understandings in ADHD experiences, particularly as critiques of ADHD (Timimi & Taylor, 2004) highlight the influence of Western culture including busy family life and the breakdown in wider community due to neoliberal pressures and the influence of the pharmaceutical industry. As such, this systematic narrative review is also limited in the finding's generalisability to only English-speaking or cultural populations. However, these studies collectively underscore some nuanced examples in which adults with ADHD navigate, internalise, and contribute to online communities and platforms about their lived and living experiences.

The themes *Who is trusted to hold expertise and validity of the concept of ADHD?* and *Where does cause and solution of difficulties lie?* highlight not only the tensions and negotiations present in online ADHD communities, but can also be considered to reflect similar tensions experienced by clinicians. Clinicians have described diagnosis as performance between interpreting individuals' experiences, whilst situated within institutional demands (Hayes et al., 2020). They describe diagnosis, in their experience with autism, as a "line drawn in the sand… and where that line is changes really, historically" (ibid, p. 825). In the case of this review, experiences such as initiating and sustaining attention or emotion regulation can be considered to lie on a spectrum of part of the daily human condition to a point where someone could warrant a diagnosis. Comstock (2015) discusses the description of experiences such as being more distractible, which have become part of public discourse of what he terms "cultural ADHD".

These studies discuss online platform and communities' numerous iterations that shape people's interactions, with a number of these disappearing over the preceding decade. Palonis, 2021 and Winter et al., 2015 highlight that platforms such as Reddit facilitate in-depth discussions and community-building efforts. The asynchronous nature and long-form content of these platforms allowed for comprehensive discussions about ADHD experiences and coping strategies. Winter et al. (2015) draws on a potential confounding factor relating to how these experiences may be operationalised clinically and socially. Of the 10 other studies included, only Steinbeck (2024) was able to draw on gender – specifically women – in relation to ADHD and online communities. What is noted in these two studies is the use of gendered discourse in relation to women and ADHD. They reported themes of disorganisation and emotional instability, may draw from common societal narratives of femininity in women. It may overlook and pathologise what is otherwise considered typical, everyday experiences. These narratives compound further in what Winter et al. (2015) describes as self-help literature that promotes neoliberal concepts. Women were subsequently encouraged to continue adopting societal gender roles, reinforcing gendered expectations. Shifts in public interest and information-seeking behaviours – temporal trends in public interest regarding ADHD – are evident in online search behaviours.

Limitations of review and ideas for future research

The online experiences of ADHD adults is an emerging area of research, with many interacting factors such as status as diagnosed or self-identified ADHD. The studies included seemed to prioritise participants who had received a formal diagnosis, and exploration of use of online media seemed to rule out self-identified ADHD (Fleischmann & Fleischmann, 2012; Fleischmann & Miller, 2012); future research could explore self-identified experiences specifically. There are also different types of social media or online communities as highlighted by Eagle and Ringland (2023), with different characteristics. These included: the manner of engagement (for example, video comment sections on TikTok and YouTube, compared to the use of Twitter.com with character-limited ‘tweets’, compared to discussion threads on Reddit); exclusive or private groups; possibly for anonymity; active or passive participants (for example leaving comments and engaging in discussion, or simply reading and upvoting discussion points); and in-group out-group dynamics which can result in disengagement and alienation (Miller, 2017).

Platforms also continue to take different and evolving approaches to attempt to verify the accuracy of information in popular posts. Lastly on an individual basis, there are differences in the preferences for choice in platform use such as disillusion with in-person communities (including lack of visibility), preferences for posting methods, factors that may enable or inhibit self-disclosure, and time spent (including mobile applications with constant availability and notification, compared to dedicated use such as on a computer). The studies are heterogenous in their aims, analysis methods, and the lens of the authors. This substantial heterogeneity among these studies precluded the possibility of undertaking a more formal and comprehensive meta-analysis. However, the design across the studies is homogenous, with only Ginnapp et al. (2023) interacting directly with participants to obtain research data. Similarly, demographics such as age, additional disabilities, and gender, could be equally pertinent to explore, as these could not be measured in the reports in this review.

The review focused on ADHD in relative isolation, though in practice it is rarely experienced alone (Thapar & Cooper, 2016). In online spaces, diagnostic boundaries are often fluid, with individuals identifying with multiple labels or using umbrella terms like “neurodivergent” (Walker, 2021). As a result, themes such as identity negotiation and navigating society may reflect broader experiences of misrecognition among marginalised neurotypes (Chapman & Botha, 2023). Future research should explore how intersecting identities shape the nature and function of online narratives.

Clinical implications

The review highlights the necessity for clinicians to understand the importance of online communities and perhaps incorporate these into formulations and shared understandings when working with adults with ADHD. This may contrast or add nuance to the understandings suggested previously that suggested online social media and communication platforms was “problematic”, associated with negative perceptions of one’s past and future (Settanni et al., 2018), and greater intensity of ADHD traits (Thorell et al., 2024; Dekkers & van Hoorn, 2022).

Subsequently, clinician understanding and use of the different concepts that are discussed in these spaces such as “hyperfocus” and “rejection sensitivity dysphoria” could be beneficial, so that clinicians can be alongside individuals in the process of self-understanding and self-growth. It would be pertinent to further understand features of the narratives shared online, and how these enable self-understanding and identification compared to more widely held information such as diagnosis, symptoms, and lay (mis)understandings. Lastly, clinician engagement should be encouraged in future research activities. Here, mitigation of power differentials through a bidirectional approach of sharing knowledge production, could be advantageous. For example, improved understandings of people with ADHD, including: individual differences within this population; or tensions in navigating what may feel to be opposing perspectives between medical understandings/pathology paradigm and the neurodiversity framework/paradigm.

Conclusion

This systematic review synthesised 11 studies to explore how adults with ADHD use social media and online platforms. Thematic synthesis revealed that these spaces support identity formation, peer support, and empowerment, but also surface epistemic tensions around diagnosis, medical authority, and community boundaries. While concerns about misinformation and over-diagnosis exist, online communities also serve to challenge stigma and broaden understandings of ADHD, particularly through the lens of neurodiversity. This is similar to community emotional support and knowledge development in the case of other lived experiences that can be “contested” such as chronic pain phenomena (as described by Barker, 2008).

Further nuanced and inclusive research is needed to account for platform differences, self-identification, and demographic variation. Clinicians and researchers alike are encouraged to engage with these evolving digital narratives, both to enhance practice and to democratise knowledge about ADHD. In doing so, we move closer to recognising ADHD not solely as a clinical diagnosis, but as a multifaceted, lived, and socially situated experience.in the production of knowledge and the ability to define one’s own identity.

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Section B: Empirical study

Interactions in identity development in trans and gender-diverse adults with ADHD: an abbreviated grounded theory design

Word Count: 7009 (plus 344)

Abstract

Emerging research suggests an association between being transgender or gender-diverse and ADHD (Strang et al., 2018). This study explored the identity development of transgender and gender-diverse (TGD) adults with ADHD using an abbreviated grounded theory methodology (Corbin & Strauss, 2015) rooted in the neurodiversity paradigm. Semi-structured interviews with 11 UK-based participants and analysis generated a tentative model with four categories, where findings indicated the application of existing theories and concepts of into two categories: stigma and shame, and trauma. In addition to these two categories, two other categories were developed which were integral to identity development: available knowledge and temporality. Within the category of knowledge, access to language and to community were theorised as potential ways to alleviate internalised stigma, shame, and the effects of trauma. These processes influenced the mental wellbeing of participants. This research addresses a significant gap in literature, reframing ADHD and TGD identities within an empowerment-focused lens which highlights the potential oppressive forces of societal structures, while underscoring the importance of addressing stigma and trauma in clinical practice, such as through more nuanced application of the including the application of the minority stress model.

Keyword(s): Trans(gender); ADHD; Identity; Neurodiversity; Stigma

Introduction

Identity development

There have been many psychological, sociological, philosophical and cultural theories that aim to define identity and its development. Those that have influenced the thinking in this research, described in brief, include Erikson’s Psychosocial Development Theory (1980) which proposes developmental tasks of which identity formation versus role confusion is crucial in adolescence, and continues beyond; Social Identity Theory (Tajfel & Turner, 1979) which theorises that individuals define themselves (and develop a positive sense of self) through their group membership or affiliations; and Symbolic Interactionism (Mead, 1934) where the “me” part of the self develops through interactions and internalisation of new societal expectations over time.

ADHD’s gendered history

The diagnosis criteria and understanding of ADHD has been based upon observations of boys (Holthe & Langvik, 2017). Girls are less likely to receive a diagnosis until adulthood (Young et al., 2020). Several factors have been suggested including research focus upon boys, gender stereotyping, and socialisation of girls to internalise their experiences which masks their ADHD (Chronis-Hinshaw, Nguyen, O’Grady & Rosenthal, 2021). Further, Young et al. (2021) argue ADHD has been deprioritised in UK healthcare due to structural barriers to services and poor clinician understanding and confidence. Research on identity development in adults with ADHD remains limited (Schott, 2012). Emerging studies suggest more people including women (Stenner, O’Dell & Davies, 2019) are claiming ADHD as a part of their self-concept. Qualitative studies using interviews and observations from online blogs and message boards suggest people simultaneously distance themselves from their ADHD by locating it within their brain and as "*the* ADHD" (Nielsen, 2017); they also identify their experiences as part of the spectrum of human experience and neurodivergence (Nielsen, 2017; Thelwall, Makita, Mas-Bleda & Stuart, 2021) with positive features (Shaw, 2021). Due to the still emerging literature, the MRP will not assume everyone incorporates their ADHD into their sense of identity.

Definition of trans and gender-diverse

There are many different variations in the definition of transgender identities, influenced by different ontological and theoretical positions. For this study, transgender (often abbreviated to 'trans') and gender-diverse identities (TGD) are defined as descriptors for "people whose gender identity and sex assigned at birth do not align based upon traditional expectations, for example a person assigned female sex at birth who identifies as a man. Gender-diverse identities can include a combination of or beyond identities in the traditional girl/woman/feminine and boy/man/masculine binary gender paradigms. Identities can include non-binary and genderfluid" (Keuroghlian et al., 2022, p. 313). Identities where gender aligns with sex assigned at birth are described as cisgender (Keuroghlian et al., 2022, p. 309). Non-binary people may or may not describe their identity as falling under the "trans umbrella"; they may also not be deemed to be trans or "trans enough" by binary trans people (Darwin, 2020).

Trans and gender-diverse identity development

Multiple models of transgender gender identity development have been proposed (Devor, 2004; Bockting, 2014; Levitt & Ippolito, 2014), although there is no dominant or agreed model. There is also paucity of research that explores how transgender adults relate their gender-identity to their wider sense of identity

(Bradford, Nova & Syed, 2019). Similarly, these models view gender identity as moving from one end of the binary of gender expression to the other (Diamond, Pardo & Butterworth, 2011). Meyer (2003) described a minority stress model, where members of minority populations experience unique and hostile stressors. Rood et al. (2016) highlight three particular proximal factors: identity concealment; internalised stigma, and expectations of rejection. The model has been applied to understand the experiences of gender-diverse individuals (Hendricks & Testa, 2012). Many TGD people face stigma, discrimination, exclusion, violence and poor health (Winter et al., 2016). Crenshaw's (1989) theory of intersectionality describes how people can experience overlapping discrimination when their identity involves multiple minority characteristics, which are greater than the sum of each individual aspect of their identity and may feel at least "doubly different" (Leven, 2020).

Associations between being trans/TGDP and neurodivergence

Studies titled as exploring gender-diversity and neurodiversity have focussed upon autism (Strang et al., 2018; Cooper et al., 2021; Yule, 2021). One PhD thesis (Bowman-Campbell, 2013) explored stigma and the experiences of LGBTQ college students diagnosed with ADHD, however none of the participants were actually transgender. There are stressors that may be experienced doubly as a TGD person with ADHD, including rejection sensitivity and shame in ADHD (Scharf et al., 2014) and in gender-diverse adults (Rood et al., 2016).

Rationale for the research

Goetz and Adams (2022)'s systematic review explored the nexus between TGD identities and ADHD reported that "17 primary research articles have been published on the TGD/ADHD intersection, with three published in 2021 alone. The existing data–as reported in 12 studies–unanimously suggest a significantly increased prevalence of ADHD among TGD persons". These include studies with children and young people (Yilidrim, Fis, Akgul & Ayaz, 2017; Strang, 2018) and adults (Dawson et al., 2017; Cheung et al., 2018; Warrier et al., 2020). Strang et al. (2014) reported in their sample of children and adolescents that gender variance was 6.64 times more common among those with ADHD (and where ADHD participants were separated from the autism group).

Goetz and Adams (2022) highlight that qualitative research is lacking to explore the extent of and reasons for this co-occurrence. Studies titled as exploring gender-diversity and neurodiversity have focussed upon autism (Strang et al., 2018; Cooper et al., 2021; Yule, 2021). One PhD thesis (Bowman-Campbell, 2013) explored stigma and the experiences of LGBTQ college students diagnosed with ADHD, however none of the participants were transgender. There are stressors that may be experienced doubly as a gender-diverse person with ADHD, including rejection sensitivity and shame in ADHD (Scharf et al., 2014) and in gender-diverse adults (Roon et al., 2016).

Aims and research questions

This study aimed to contribute to the literature for adults with ADHD, particularly where previous research and clinical practice has focussed upon childhood ADHD, and particularly so in cisgender boys. This exploration is pertinent due to the co-occurrence of transgender/gender-diverse adults who also have ADHD. Due to the complexities described in identity development, as well as the tensions between the neurodiversity and medical/diagnostic understandings, the research also aimed to examine how participants related to ADHD; for example, how participants may identify with or reject ideas from the neurodiversity paradigm and movement. These are: (1a) To explore how transgender/gender-diverse adults with ADHD understand their view of themselves, their experiences and identity; (1b) To explore whether participants claim ADHD as part of their identity or self-concept; and (2) To explore if there are understandings of any interactions between having ADHD and being TGD.

Method

Epistemological position

The research was proposed from the critical realist ontological position, where some form of ‘real’ or ‘authentic’ reality is assumed, however this can only be partially accessed due to historical and socio-cultural influences and the differences in meaning that individuals create (Braun & Clarke, 2013). Current understandings of ADHD and neurodiversity can include differences in biological brain functioning, as well as people’s own subjective experiences which are influenced by cultural attitudes and social norms.

This study is grounded in a contextual epistemology, which views knowledge as shaped by social, cultural, and political forces rather than fixed standards (Hendricks, 2005). One such force is neoliberalism, a dominant paradigm that emphasises individual responsibility, productivity, and self-governance (Harvey, 2005). In mental health, this often reframes distress as personal failure and encourages self-comparison to normative standards (Miller & Rose, 2008). Within this lens ADHD may be seen less as a disability and more as a barrier to productivity, something individuals are expected to self-govern through medication, discipline, and self-regulation. This framing influences both clinical discourse and how individuals with ADHD narrate their own experiences.

Neoliberalism also casts identity as a personal project, something to be curated and made legible within institutional systems. While this can support self-determination (for example, through gender exploration), it can also pressure individuals to present coherent, system-recognisable identities, especially in healthcare and legal settings (Spade, 2015).

In line with a contextual epistemology, this study adopts a flexible, situated approach, where knowledge claims are evaluated based on inquiry purpose, theoretical stance, and relational dynamics. Participant testimony was granted greater epistemic authority than it might receive in clinical or diagnosis-based contexts.

An abbreviated form of Corbin and Strauss' (2015) grounded theory methodology was deemed to be in line with the above philosophical positioning. The most recent fourth edition of Corbin and Strauss' (2015) *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory* has evolved from a postpositivist position to one which approaches a constructivist view (Rieger, 2018), as they describe how research participants try to make sense of their experiences, both to themselves and the researcher.

Research design

An abbreviated grounded theory design was considered particularly useful given there is relatively little known about the study area. Due to the time-limited nature of the research, an abbreviated version was used.

Measures

Semi-structured interview schedule

Interviews were conducted to attempt to understand participants' subjective experience, and to allow exploration and probing of content in comparison to other methods such as analysis of online data. A semi-structured interview guide was used which contained prompts for open questions, and participants were encouraged to speak to any areas they considered relevant in addition or instead of the questions posed to them. The interview schedule was adapted (Appendix D) as the interviews progressed to support development of theoretical saturation (Corbin & Strauss, 2015).

Ethical considerations

Risk of distress

Due to the nature of the study in discussing TGD and ADHD experiences, this population in their participation may be impacted by distress in relation to concepts of identity and broader societal treatment. This amplifies its significance when considering increased prevalence of mental health presentations among transgender and gender-diverse people and people with ADHD (Eccles et al., 2024; Rood et al., 2016). Mitigation of this included participants being given an information sheet and explaining signposting services for post-support (Appendix E).

Ongoing consent

The lead researcher proactively encouraged participant autonomy in knowing about and being able to act upon either temporarily pausing or entirely withdrawing from the study, within a specified timeframe of approximately two weeks from study participation. These measures were invoked during introduction of the consent form, and being reminded of these processes throughout the interview stage (Appendix C; Appendix D).

Empowerment and agency

A significant consideration and intent prior to the study taking place, was for participants to know enough about the lead researcher from the study poster advert. This involved presenting a pithy but adequate positionality statement, including self-disclosure of neurodivergence and queerness, and stating personal pronouns. This information was accompanied by a profile photograph (Appendix B). Lastly the interview schedule concluded with a 13th question soliciting the participant’s feedback on their experiences of the research study. It was an attempt to foster collaborative engagement, aligning itself closer to participatory research approaches. Feedback participants gave was acted upon accordingly, within the constraints of the project’s resources.

Data security

Audio recording of interviews were securely stored as encrypted audio files. Transcription of these were into anonymised text, subsequently destroying the audio files. Access to full transcripts was restricted to the leader researcher and supervisor. Participants' anonymity is maintained through pseudonyms, which were chosen by the participants.

Participants

Inclusion criteria

Participants were adults in the UK who defined as TGD, having ADHD and as the primary presentation in their experiences, and had adequate access to digital technology to partake in online interviews. This is represented in Table 1 below.

Table 1

Inclusion criteria

Criterion	Criterion implementation
Gender	Self-identify as transgender, non-binary, or gender diverse
Neurodivergence	Self-disclose having ADHD and consider their ADHD to be primary to their experiences with other diagnoses or forms of neurodivergence (e.g., autism).
Age	Are aged over 18
Geographical Location	Live in the UK
Interview access	Have access to technology that allows them to complete an interview online (internet connection, and a laptop/phone/tablet), preferably with a camera

Recruitment and theoretical sampling

Participants were recruited using a combination of convenience and purposive sampling approaches. It involved social media adverts (Appendix B) through Twitter and TGD and ADHD-related subreddits on Reddit, as well as outreach through closed social network groups, including Discord and Facebook. Other adverts were hosted through ADHD and trans support websites. The purposive sampling ensured that the study captured experiences relevant to the research questions and aims, while the opportunistic component acknowledged possible difficulties in recruitment of TGD people with ADHD. The recruitment periods were very successful, reaching participant numbers relatively early on. The online nature of recruitment seemingly improved accessibility and facilitated a place of safety for participants, particularly those who might have otherwise faced difficulties to participate in-person, for example trans feminine people.

Sample demographics

Eleven participants were interviewed – four non-binary, three women, one man, one queer, one genderqueer, and one genderfluid. Participants had an average age of 29 years. Educational backgrounds ranged from high school to university (masters), bachelor's degree was most common (seven). Six participants disclosed other neurodivergences included autism (four) and dyspraxia (two). Eight participants had an ADHD diagnosis. Regarding first self-understanding, eight participants understood their ADHD first, while two understood being trans and/or gender-diverse first.

Table 2

Demographic features of participants

Age	Ethnicity	Gender/ pronouns	Education	Other neurodivergence	ADHD diagnosis	First understanding: ADHD or TGD
25	Black	Trans woman; she/her	BSc/BA	No	Y	Trans
27	White British	Non-binary; they/them	BSc/BA	Autistic	N	Trans
56	White Irish	Non-binary. Agender (not main	MSc/MA	No	N	ADHD

		label); they/them				
25	Black British	Female; she/her	BSc/BA	No	Y	ADHD
33	Black British	Trans man; he/him	College diploma	No	Y	Trans
28	White British	Female; she/her	BSc/BA	Dyspraxia; suspected autism	Y	ADHD
30	White British	Queer – non-binary; they/them	BSc/BA	Autistic	Y	ADHD
27	Black British	Gender queer; they/them	BSc/BA	Autism	Y	ADHD
22	Black British	Queer; she/her	High school	No	N	ADHD
21	White British	Genderfluid; they/them	A-levels	cPTSD; Autism; Auditory processing disorder	Y	ADHD
31	White British	Gender fluid/non-binary; they/them	MSc/MA	Autism; Dyslexia; Dyspraxia	Y	ADHD

Data analysis

Analysis (see Table 2) was completed following Corbin and Strauss’ (2015) selection of techniques and guidance for a flexible and adaptive approach to this abbreviated grounded theory analysis. To support the identification of concepts, coding using gerunds was prioritised (Birks & Mills, 2023). Transcripts were initially organised and coded using NVivo 12 Pro, using the memo writing feature. Diagrams were also drawn out on paper and then created digitally using Microsoft Word. Microsoft Excel and Word were used to support using the Conditional/Consequential Matrix (Corbin & Strauss, 2015; see example Appendix G) for analysis.

Process

The following reflects the steps involved as part of Corbin and Strauss's (2015) grounded theory methodology. It outlines the three stages implemented and their importance and relationship to this specific theory's development. Whilst presented linearly here, the process was iterative and not conducted as separate or distinct stages.

(1) Open coding: line-by-line, paragraph-by-paragraph and incident-by-incident coding to generate initial codes and concepts; constant comparison (within and between transcripts) to identify similarities, differences, and exceptions/outliers; memo writing; analytic techniques to ask questions of the data and support property-dimension building were used, including who, what, why, when, how, so what, and how much?, asking meanings of frequently used words, for example "support", and waving the red flag or looking out for terms indicating assumptions, biases or extremes such as "definitely" "always" "that's just how it was". This encourages the researcher to critically engage with the codes, establishing understandings of relationships, underlying assumptions, and linguistic patterns, as well as significant tensions in participants' perspectives.

(2) Axial coding: continued use of memo writing, and diagrams to support linking concepts into categories with properties and dimensions; use of the Conditional/Consequential Matrix to explore relationships, including the influence of macro and micro-level aspects of the data; considering process including routine and unique action-interactions, considering action-interactions as sub-processes with

phases or stages; and theoretical sampling to explore development of categories and their properties and dimensions. It is worth noting axial coding is a term rarely explicitly used in the guidance.

(3) Theoretical integration: the validation and theoretical saturation of relationships between categories, and the properties and dimensions within properties. Continued constant comparison method; checking for outliers/exceptions and variation; continued use of memos and diagrams; descriptive summary or storyline (also discussed by Birks & Mills, 2023) was used to support integration of; and due to the exploratory nature of this study, a core category was not deemed to fit within the generated mode. This is per their recommendations that while a core category can be useful and unifying, the data/categories are not to be forced into one. It is important to establish grounded theory ultilise an iterative approach in its stages, and as such they are not conducted as separate or distinct stages. Instead, they moved back and forth.

Quality assurance and reflexivity

Grounded theory studies have been critiqued for being biased by the researcher and previous knowledge sought, including the use of scoping reviews to complete the research proposal (Sebastian, 2019). Corbin and Strauss (2015) discuss that a researcher cannot be fully blind to literature and ideas prior to the area of study, and so self-awareness is one of the conditions required to produce quality research. This was maintained using memo-writing (Appendix J) early in the research and a research diary (Appendix K). The researcher also maintained methodological consistency through only using the procedures offered by Corbin and Strauss (2015) and that were consistent with the ontological position. Time was spent coding line-by-line for each transcript to stay grounded to the data using the participant’s words, and to minimise the likelihood of imposing selective attention or generalisations that may align with the researcher's experiences and prior knowledge (ibid).

Theoretical frameworks and positioning

The researcher was aware of the need for reflexivity to be aware of potential biases. The researcher identified as White British, neurodivergent though not through ADHD, and queer; this information was made known on the study poster (Appendix E). The researcher also has some experience completing assessments for adult ADHD. This proximity was considered to potentially increase the risk of some experiences being overlooked, for example The researcher discussed these aspects and reflections from their research diary, including surprise at some of the findings, in supervisor meetings. However it was also deemed important to be open, given the historical contexts of both transgender and neurodiversity research being conducted from an outsider perspective with interpretations that can be deemed pathologising (Chapman & Carel, 2022) or deficit-focussed (Goetz & Adams, 2022).

Results

This study aimed to investigate the experiences and identity development of TGD adults with ADHD, including pertinent interactions between these two aspects of identity.

Overview

During the analysis, four main categories were identified inductively from the data, including associated subcategories and additional sub-subcategories to provide greater depth and represent the variation in experiences. (Table 3).

When analysing the data, theoretical codes *Stigma and shame* and *Trauma* (defined below) were developed as coding advanced, allowing for abstraction and unification of patterns within the data. Theoretical integration was conducted to connect these codes into a coherent framework, informed by both participant narratives and extant theory. The application of extant theory to coding was employed selectively to support the development of theory with explanatory power, ensuring that it remained grounded in participants' lived experiences. This integration was rendered through storyline, which served as a tool to present the emerging theory, as argued by Birks and Mills (2024). Stigma, shame and trauma are often considered to interact with each other (DeYoung, 2021; Dunlop, 2022).

Stigma

Stigma can be conceptualised as the co-occurrence of constituent components: labelling, stereotyping, separation, status loss and discrimination (Link & Phelan, 2001). Further, they suggest that stigma occurs in the context of exerting power against a minoritised group or group member. Discrimination such as biphobia (discrimination against bisexual sexual orientations) and transphobia (discrimination against TGD people) can be perpetuated within the minority group of lesbian, gay, bisexual, transgender and queer (LGBTQ) people; this can potentially be experienced more painfully than if it were perpetuated by heterosexual cisgender people (Dunlop, 2022). Individuals can come to internalise repeated negative messaging, which may result in poor self-esteem and self-criticism, for example internalised transphobia (Rood et al., 2017). It can also result in the perpetuation of these bias and discrimination against individuals with similar identity characteristics (Bos et al., 2013).

Shame

Shame is conceptualised as the internal sense of having violated potentially broad and unspoken social rules or norms (Dunlop, 2022). The individual in turn views themselves as flawed and less worthy of belonging (Brown, 2006) or having their needs met which impacts upon their self-identity and mental health (Gilbert, 2019).

Trauma

Trauma refers to emotional response or “inner injury, a lasting rupture or split” (Maté & Maté, 2022, p.31) to distressing events that overwhelm an individual’s ability to cope. Trauma is subjectively appraised, meaning it can originate from a wide range of experiences, including both single traumatic events and complex trauma resulting from repeated or sustained exposure (Beattie, 2023). These experiences may involve various forms of abuse, rejection, shaming, bullying, or discrimination. Scarrone Bonhomme (2019, as cited in Beattie, 2023) describes the phenomenon of identity-based trauma as:

> A deep-rooted feeling of discomfort about a given identity characteristic which society has conceptualised as inadequate, problematic, or defective. Beliefs about what holding this characteristic means are then both actively and passively absorbed. These beliefs have the potential to elicit anxiety about accepting oneself or being accepted by others. (ibid, p. 20)

Dunlop (2022) highlights that healthcare-related trauma is commonly reported among queer individuals. For example, interactions with gender identity clinics may be experienced as traumatic due to factors such as the need to disclose deeply personal information to relative strangers, prolonged wait times, and the potential for clinicians to delay or deny access to gender-affirming medical interventions. For TGD individuals, these experiences can undermine the perceived legitimacy of their identity and result in a profound loss of self-determination.

Table 3

Summary of categories, subcategories, and sub-subcategories

Categories	**Subcategory**	Sub-subcategories
1. Enduring misrecognition to internalised shame	a. Response to power	• Resistance ○ Feeling the social norms and living how you want anyway ○ Development of self-compassion ○ Community • Maintaining psychological safety ○ Cost-benefit analysis ○ Concealment and 'masking'
2. Layered Trauma: Violence, Neglect, and Being Unseen	a. Emotional manifestations and behavioural responses	• Rejection Sensitivity ○ Preferring isolation/social withdrawal and • **Anger** ○ Emotions more intense with ADHD ○ Response to injustice
	b. Invalidation	• Assigned female at birth: ADHD traits dismissed in childhood • Double invalidation

3. Available Knowledge	a. Taking in knowledge	• Seeking information out • “I didn’t realise we could do that” – exposure to different ways of being • Information online ○ Online representations more relatable • Information unavailable in professional advice
	b. Language	• Mismatch between ADHD label and concept • Having to settle on shared language and concepts for gender • Disorder in the label of ADHD
4. Temporality	a. Comparisons	• To others ○ Feeling left behind ○ Making sense of things by looking back over one’s past.
	b. Speeding up and slowing down	• Initial distancing and non-identification with identities • Executive functioning as both speeding up and slowing down transition

Findings

Context

Most of the participants spoke to features of the overall **context** including micro and macro-level conditions as described in the Conditional/Consequential Matrix (Corbin & Strauss, 2015) that had impacted their identity development in some way: *"You work with healthcare services for you to be able to fix this problem within you, rather than societal stuff ,which is then where you get the neurodiversity kind of paradigm and the movement……It's actually more macro kind of structures that are primarily causing these problems… There wouldn't be this desire to kind of keep labelling anything that isn't neurotypical, anything that isn't cisgender, white, etcetera… I was really seeing a lot of that, like the parallels between the healthcare settings and then kind of educational settings" – Link*

Process

The findings that describe the processes involved in the identity development will be presented as they related to each category, subcategory and sub-subcategory (where applicable).

1. Enduring misrecognition to internalised shame

Participants described action-interactions and consequences, or experiences and outcomes, of being misunderstood and labelled by others. For example, labels of "lazy" or not applying full effort were described by all but one participant. With regards to gender, every participant described a sense of difference which was noticed by their parents/caregivers and peers. These related to conceptualisations of stigma, and internalised responses of shame.

"Yeah, I was kind of brought up full of shame because I wasn't the child my parents wanted or thought they wanted, and that would deem a lot of shame, a lot of transgenerational trauma and what have you." – Aodh

These impacts were felt particularly strongly in non-binary participants, and also those who had experienced similar stigma of being misunderstood or unseen due to their sexual orientation; three participants describe this intersection of stigma.

"…it felt like so much of the narrative is very binary, and very like, full transition, or you're not properly trans enough. It's kind of like I never felt gay enough. I was like 'oh great, I've got another struggle to pick being in the middle of'. It's not very accepted by other queer people." - Edgar

a. Response to power

Participants experienced the effects of stigma through repeated critical judgements and misunderstandings from others about their ADHD and gender identity, and resulting internalised shame. They enacted active **resistance** against these powers.

All participants expressed enacting resistance in some way, which took various forms of **feeling the social norms and living how you want anyway:**

"*But when you live your life true to yourself, and they see that, okay, this person is doing well, they might have a change of mind. So you should live your life to please yourself, to be happy with yourself, and that is the most important thing to me."-Blue.*

For more than half of the participants, understanding oneself through the neurodiversity paradigm, this facilitated **the development of self-compassion:**

"[Receiving the ADHD diagnosis] was like a vessel to give myself more understanding, more self-compassion" - Edgar.

Others described the practice of positive affirmations:

“It’s my positive self- talk. I talk to myself and I tend to learn more from myself”. - Mirror

Participants who had connections to a **community** of other people who had ADHD (or were neurodivergent) and TGD (or LGBTQ people more generally) described it as access to support and understanding. Participants who did have this access, or at least incidental exposure, expressed an awareness that this is not universal:

“It just depends on how much people are able to have a support network of other neurodiverse and non-cisgender people. Because I feel like I'm very fortunate, very privileged, to have a very large group of friends who are all kind of the same.” - Atlas

b. Maintaining psychological safety

Participants described a sense of having to balance the aforementioned resistance to stigma and shame, with maintaining their psychological safety.

All participants spoke to conscious and unconscious processes of **cost-benefit analysis** for situations where they would enact resistance, including disclosure of their identities. This was particularly experienced with regards to being TGD, though some participants had to perform this analysis for how their ADHD would be understood at work or when navigating the healthcare system:

“Often it's just pragmatic. It's not like, they'll find out and be awful. It's more like I haven't got the spoons to get into this with people you know.” - Aodh.

Almost all participants expressed situations where they engaged in **concealment and masking** of their identity through non-disclosure of their gender if this was misperceived, or through actively inhibiting ADHD traits:

“I try to make an effort with how I'm talking, or fidgeting or how I present myself. I think it's hard, because, it really shifts and changes. Like some social groups, or

sometimes I feel the emotional atmosphere. If I can sense myself being a bit like hyperactive, getting really excited about something, it tends to turn people off or people tend to be annoyed, or I feel like I'm taking up too much space. So I kind of hold myself back." – Edgar

"I just had to be in my silence…because I wanted to feel among others." - Riri

2. Layered Trauma: Violence, Neglect, and Being Unseen

Many participants described having experienced difficult experiences, with some explicitly naming it as "trauma". These included both acute incidents such as childhood abuse and neglect, and more diffuse but chronic identity-based experiences of being dismissed, disbelieved, or neglected within educational, healthcare, and family systems. The layering of these harms, especially when left unacknowledged, contributed to a sense of emotional fragmentation and vulnerability in adulthood:

"People didn't have the awareness that I was actually suffering from something inside, that has to do with emotions and the way I was being raised. What I felt on the inside was absolutely different to what others perceived about me'" – Az

a. Emotional manifestations and behavioural responses

Participants described emotional and behavioural impacts of trauma. This included described traits of **rejection sensitivity** (similar or related to hypervigilance in trauma), with some naming this explicitly:

"I thought that my entire family hated me because I came out as trans…They just asked, "oh okay, like you sure?". Like, "What's going on? Can we talk about that?". And I thought that that was them being like "oh, no, we don't want you here anymore. We don't want you like, as part of our family". And that was just the rejection sensitivity." - Laurie

About half of participants described **preferring isolation** to avoid rejection and having their emotions disturbed:

"that's why most times I am usually confined to the walls of my bedroom because I really don't want to be associated with something that puts me off my mood." – Az

Participants described **anger** which also served as a protective response to perceived injustice or mistreatment of themselves or others. Associated with this, almost all participants highlighted that they also experienced emotions more intensely as part of their ADHD.

"It's the same with the sense of injustice when you see it, how much it kind of really sets you off. Like, there's just such a strong response to it, if you see something that is unjust. For ADHD communities, it's a lot more than that. And it's really hard to know where to put all those emotions when you're feeling it, you know so strongly, so intense that it's just stuck within you. And it's like the champagne bottle" – Link

b. *Invalidation*

Almost all participants described having experienced **invalidation**. In particular, participants **assigned female-at-birth (AFAB) had ADHD traits and patterns dismissed in childhood.** Participants were more likely to be referred for assessment and receive an ADHD diagnosis in childhood if they were observed to be aggressive; this included AFAB and assigned-male-at-birth participants:

"So when I was very young…I'd come home from school and have these massive meltdowns because I'd been masking at school all day, and my mum took me in to get me tested for ADHD…I looked back at my medical notes, and it literally said in them that I was a girl, so they weren't going to do further testing. I was shocked by that." – Laurie.

Some participants described **double invalidation** of their dual TGD-ADHD identities.

"They tend to doubt your abilities because they feel you're not of this world… You do not have the same beliefs…I have a friend who has told me how I'm not in my right-thinking faculties. And I'm like 'Wow!'" - Riri

3. Available knowledge

One of the factors that facilitated self-understanding and identity development was exposure to others like you, and access to information.

a. Taking in and producing knowledge

Almost all participants described pivotal moments where they were **seeking information,** often through searching online first (particularly for ADHD). For other participants and particular with TGD, this was facilitated through **exposure to different ways of being**.

"I had to look into a lot of research about human behaviours, about the little symptoms I was getting. Then I had to meet the professionals where I can deal with it". - Cherry

"So meeting someone else who was trans opened up this "Oh, I didn't realise we could do that?". – Laurie

Every participant described seeking out **information online.** These took the form of narratives, videos, or being part of groups and discussion platforms. Participants described this information as being more relatable:

"It's very much like the DSM is just very dry and doesn't provide like actual experiences." – Atlas

Some participants described **information unavailable in professional advice**, and that was only available through within-community knowledge**:**

“So not every trans person will take HRT, but… I first started noticing symptoms like menopause… And it's frustrating that a lot of trans masculine people don't really talk about it. Like I've tried looking online for accounts and stuff, and I only really found this out when I was talking to another trans masculine friend about it, who's kind of gone through a similar experience. And I was saying that of all the transmasculine people that they know themselves, only one person has not gone through it and then everyone else has gone through similar symptoms to what I have in terms of - they can range from something it's like bits of frustration and fatigue all the way up to feeling like this concept of suicidality…for transmasculine communities, it's just like it isn't spoken about a lot” – Link

b. Use of language

Approximately half of the participants described difficulties with the **language** available to understand and express ADHD and gender-diversity. This was particularly around a perceived **mismatch of the ADHD label and concept**.

“But yeah, definitely the name itself I think is problematic in that, it's the joke, isn't it? About someone with ADHD? It's almost like people think that it's enough to get diagnosed, if you're like ‘oh, look over there’ and it's like, you get distracted by this thing that's over there…It's very frustrating to kind of have that levelled at you when it's like… that it's not a deficit in attention, I think what's happening is that there's so much stimuli in the environment you're trying to take lots of information and at once it's not about being inattentive or not paying attention. It's actually something around, I don't necessarily think it's not paying attention, but it’s paying too much attention to, and I'm trying to take everything in or as much as I'm aware of, I'm trying to take it all in at once” – Link

Non-binary participants described **having to settle on shared language and concepts for gender:**

"I think as soon as you're like I'm more gender fluid, people expect one end of the spectrum to another. And it's like that also isn't how it works. It's kind of, I do kind of feel like I'm kind of almost gender-fluid within a kind of non-binary thing, but explaining that to cis people is difficult. It's easier to say like, I'm non binary. Rather than be like, I'm non-binary, but I'm kind of gender-fluid. And then people are like, what does that mean?" – Atlas

Linking to the next category of identity, there was variation in the language of having **disorder in the label of ADHD**, and its possible influence upon one's self-conceptualisation**:**

"*I think…it's hard. Because, having kind of implies, yeah, like, you have something you can pick up and put down. But then, disorder…? What is disordered? And also I don't feel like it's a superpower either, you know? [Laughs]. I think that's hard for me, because I admit it mainly provides struggles. It's a bit unsure for me, in terms of like the language." - Edgar*

4. Temporality

Whilst all the aforementioned categories relate to identity development at the TGD-ADHD nexus, woven throughout the narratives shared was the influence of differences in temporality upon identity.

a. Comparisons

All participants described a sense of making **comparisons to others**, consciously or unconsciously, which typically included feeling "**left behind"**. The majority of participants described **making sense of things by looking back over their past.**

“I do struggle a lot with comparing myself to other people because of that. Like, because of my ADHD, I feel like I'm constantly falling behind other people. So I felt that a lot with my transition and trying to set sort of long term goals, constantly made me feel like I was falling behind.” - Laurie

b. Speeding up and slowing down

Participants described an **initial distancing and non-identification** with both ADHD (if this was not diagnosed in childhood) and especially with gender.

“We had great conversations that really got me thinking. But it was all kind of stalled because I couldn't see how I could be non-binary. So that's kind of floats around the back of my mind *for ages and ages*.” - Aodh

An interaction between ADHD and gender, was the impact of **executive functioning as speeding up and slowing down transition.**

“I know that some people can struggle with figuring out their like their name. Whereas for me, it wasn't even that much of a strong feeling. I was like ‘oh, I quite like this one’. And I was like, yeah, that's it. Decision made, done, sorted. But then later on it took me a long time to finalise my middle names actually. Because I think maybe I didn't get that done in the early kind of hyper-focusing, ‘let's do this’ stage. So then it took me quite a while to actually finalise and finish that”. – Gwen

Outcomes

Every participant spoke about the impact that the overall context and the effects of stigma, shame and trauma had upon on their mental health and wellbeing, in particular low mood, low self-esteem and anxiety. Participants described experiences which modulated these outcomes, for example *access to knowledge:*

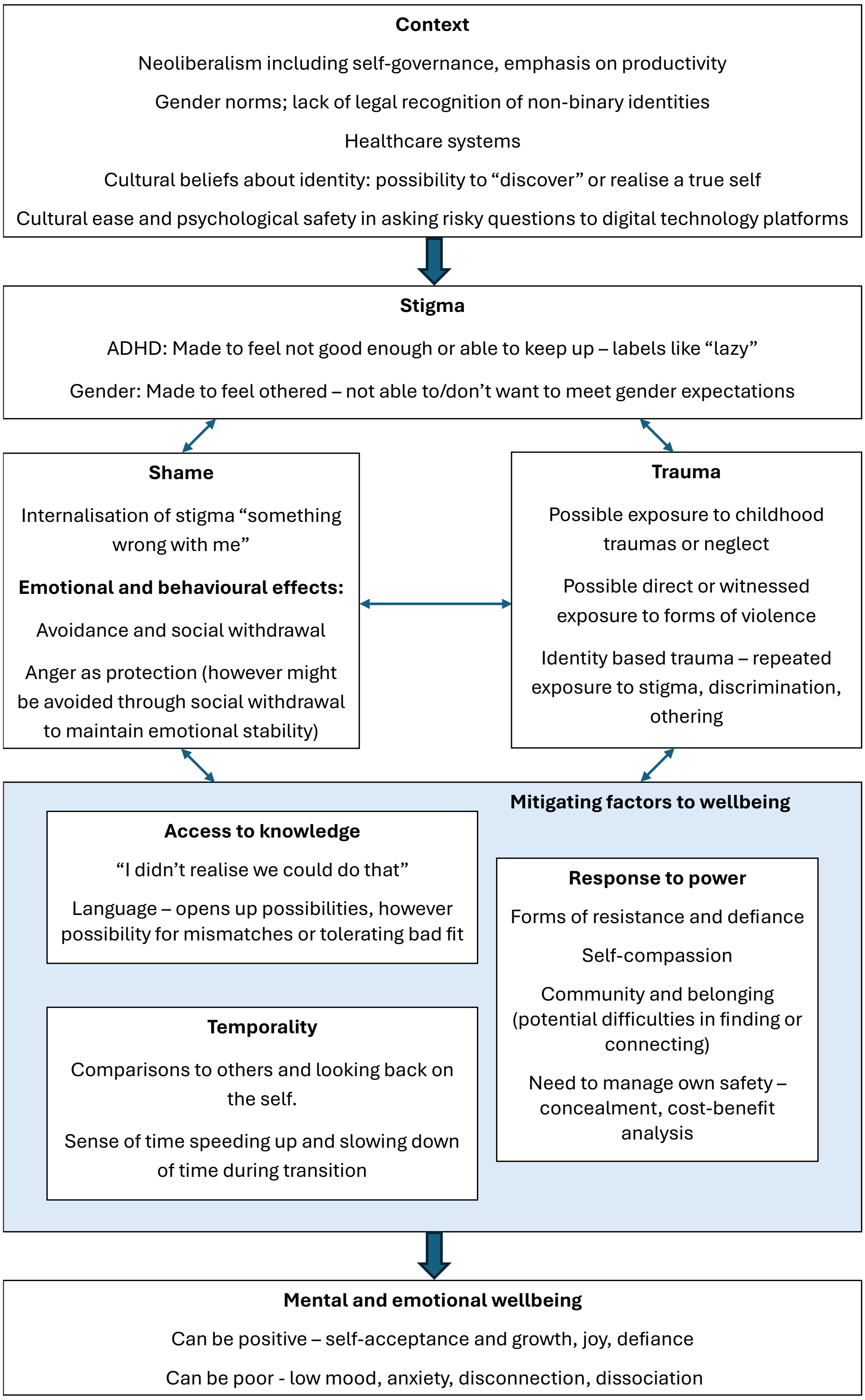
“the diagnosis really helped give me a bit more understanding, but especially with my mental health, like I had done CBT. I tried a little bit of counselling. I'd taken a whole range of antidepressants, but like never really touched the real signs and symptoms of anxiety, or, like, I guess the disorganised-ness that maybe I didn't attribute to anxiety at the time. But I think, having that diagnosis helped me really piece parts of myself together, that I hadn’t been able to before and just let me give myself a bit more understanding rather than being so, like as hard on myself.” - Edgar

Model diagram

The analysis was synthesised into a diagrammatic model, (Figure 1).

Figure 1

Model of identity and interactions in TGD adults with ADHD



The model depicts a provisional theory for interactions in the dual ADHD-TGD identity development. The model is set within the context of the sample of participants living in the UK. Participants described a context where, from a young age, they experienced an educational system that prioritises individualistic achievement and exam performance in particular subjects (those likely related to league tables, rather than subjects such as art and physical education). Higher ratios of pupils or learners to teachers/tutors may have influenced participants narratives of being unsupported and left to “fall behind”, as well as feeling overlooked. Many participants described receiving feedback (typically this was disapproving), as children from adults about how they did not behave like or enjoyed being treated as their gender assigned at birth. Participants described difficulties with the healthcare system including being disbelieved, “infantilised” or simply having referrals for assessment for ADHD refused. Some participants conceptualised their experiences in terms of “my identity” and “figuring out…”, speaking in ways that suggested that their ADHD and particularly their gender had been “realised”; this concept is described psychoanalytically by Saketopoulou and Pellegrini (2023, pp. 15-22) as cultural exposure to core gender identity or “’born-this-way’” theorisations of gender”, rather than all gender identities (including cisgender) being developed through dynamic and unfolding processes. Non-binary participants appeared to resist these understandings of gender identity, however as a consequence they appeared to experience greater levels of direct discrimination, othering, and having to acquiesce in how they described their gender so that others could understand them.

Through exposure and the imposition of these societal structures and norms, participants spoke to the process of oppression and feeling “othered”. Repeated experiences in these contexts over time increased the likelihood of participants to experience shame, internalised stigma, and trauma; these were inter-related and therefore represented in an overlapping Venn diagram. Participants’ access to knowledge and community were significant factors in being able to escape these forces, and facilitated their ability to respond. All participants described ways of living in ways where they were able to resist the pressures of social norms. However it is pertinent to acknowledge that participants described a process of weighing up environments when/where it was deemed safe and responsive enough, for example workplaces that were understanding of ADHD and of their TGD status. These factors ultimately contributed to participants’ mental and emotional wellbeing. The model is encapsulated within the category of *Temporality*, highlighting the ongoing and dynamic nature of reflection and (re)interpretation of the past, meaning-making, temporal transitions, and developing a cohesive self across temporal experiences, and inform choices in the present and future. As above, there were differences in perceptions of gender over time being fixed or iterative, between binary and non-binary participants. In comparison, ADHD was viewed as static. When there was less opportunity for participants to resist the power and influence of shame, stigma and trauma, they reported more frequent experiences of self-isolation, concealment of identity, and avoidance of certain topics of conversation. Effects on mental health outcomes were noted, including participants who described isolating themselves being more likely to report low mood and anxiety.

Discussion

This study aimed to investigate the experiences and identity development of TGD adults with ADHD, including pertinent interactions between these two aspects of identity. The approach used an abbreviated grounded theory methodology (Corbin & Strauss, 2015).

A tentative model was developed to represent the emerging theory of identity development, which during data analysis incorporated extant theory of stigma (Link & Phelan, 2001) including internalised stigma (Rood et al., 2017; Dunlop, 2022), shame (Gilbert, 2019; DeYoung, 2021) and trauma (Maté & Maté, 2022). Since the current research study was proposed and was being conducted, quantitative studies have been published that support the linkages between the concepts of “neurodivergent discrimination” and “neurodivergent stigma”, including internalised transphobia, in predictions of psychological distress in TGD college students who are neurodivergent (Farquhar-Leicester et al., 2024).

Strengths and limitations of this research

Goetz and Adams (2024) reported that of the few studies available that explore the TGD-ADHD intersection, these were predominantly studies exploring prevalence. Where qualitative information was available, this was in the form of reflections upon case study examples. None of the studies in their systematic review “avoided deficit-framing” of ADHD. A strength of the current study is the commitment to the neurodiversity paradigm which is embedded in the positionality, care taken to consider empowerment, and the curation of the research questions including the semi-structured interview guide. The study has also endeavoured to hold the differing perspectives on the ADHD experience. Corbin and Strauss (2015) acknowledges that even with the use of extensive strategies to mitigate and manage potential biases, researchers will bring their own interpretations.

Researchers and clinicians who have different positionality to the constructs of ADHD for example, may generate different conceptual links. Further qualitative exploration is warranted, including the use of different qualitative methodologies. For example, discourse analysis could further interrogate features highlighted in this study's tentative model about the use of language in discovery of the concept and possibility to be TGD and ADHD, and the communication of this to others.

The study could be considered to have given a lot of space to potentially negative concepts such as shame and trauma, where have been concerns raised by members of the TGD communities in particular that this associative link has historical and current concerns about searching for cause and potential resolution (Saketopoulou & Pellegrini, 2023). However similarly to Saketopoulou and Pellegrini, the current researcher takes the position that to avoid topics of trauma and shame would detract from understanding the complexity and fluidity in the processes of identity construction, that have historically been afforded to cisgender people (for example Freud's Little Hans case study, ibid).

Implications

Clinical and research implications

The research explored the TGD/ADHD intersection or nexus of identity, where the vast majority has reported upon association or prevalence (Goetz & Adams, 2024); only one study was found to report upon clinical implications. Therefore the current study has potential significance for the research literature and clinical practice.

This research contributes to current understandings of identity-responsive and trauma-informed clinical practice. Participants often described their ADHD traits being repeatedly misunderstood or dismissed in childhood, particularly AFAB participants, where traits like inattention or emotional sensitivity were perceived as laziness or low effort; this endorses previously suggested gendered diagnostic biases (Young et al., 2020). Similarly, gender-nonconforming behaviours were met with shame or surveillance, contributing to early misrecognition and identity suppression. These experiences reflect how TGD and neurodivergent youth often face chronic invalidation, leading to adaptive strategies such as masking, emotional numbing, or social withdrawal, which can obscure or mimic ADHD traits (Botha & Frost, 2020; Beattie, 2023).

Participants also reported distinctive experiences of time, shaped by both ADHD and gender transition. Some described rapid decisions during hyperfocus states followed by periods of inertia; others found waiting for institutional validation (such as diagnosis or gender-affirming care) difficult to endure, creating temporal dissonance. These experiences influenced self-concept and perceptions of “progress” relative to others. Such narratives align with motivation-based ADHD models that describe a neurocognitive aversion to delay (Sonuga-Barke, 2003). Clinicians should explore subjective time in formulation, for example how individuals perceive urgency, delay, and being “left behind”. This can contextualise functioning, reduce misinterpretation, and support compassion by framing time-based difficulties as responses to systemic barriers, rather than personal failure.

Participants knowledge of concepts as well as lived experience that is not available to professionals is particularly pertinent to explore further in assessments. The tentative model also provides a framework to support the facilitation of peer support groups in more clinical settings. These can provide individuals access both to forms of knowledge and language, and also community.

The linkages in the generated model of stigma, shame and trauma contribute to the development of nuance in models that have been applied to understand the experience of minority stress (Meyer, 2003) which has been applied to TGD (Hendricks & Testa, 2012) and autistic people (Botha & Frost, 2020). Overall, the research aims to also further the conceptualisation of ADHD and provide further nuance and important context for clinicians completing ADHD assessments. The potential to alter the name or label of ADHD as "disorder", whilst potentially quite radical in scope, could also result in dramatic changes in the societal and internalised stigma and shame that all participants expressed.

Conclusion

This is the first comprehensive qualitative study, using semi-structured interviews with eleven participants, that has explored the identity development and interactions between being TGD and having ADHD/being an "ADHDer." The approach is embedded in the neurodiversity paradigm, reflected in its positionality, and focus on empowerment, where the limited research available currently has been considered to be deficit-focussed. By addressing this gap, the study acknowledges the intersectionality of marginalised identities, specifically the nuanced experiences of individuals navigating the challenges of dual minority status. It also explores the role of systemic inequalities in shaping identity, coping strategies, and the navigation of stigma. The study used an abbreviated Corbin and Strauss (2015) grounded theory methodology, and a tentative model and provisional theory were developed. This highlighted how societal structures and repeated exposure to oppressive forces such as stigma increase the likelihood of the development of internalised stigma, shame, and the effects of living with/after trauma. These can be resisted through the influence of access to knowledge, supportive relationships, and access to community.

Furthermore, the research provides a novel perspective on resilience, emphasising the protective role of affirming environments in fostering self-acceptance and reframing neurodiversity as a source of strength and identity affirmation. The study provides more nuance and integration of the application of theories and models such as the minority stress model.

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Section C: Appendices of supporting material

Appendix A: Salomons Institute Ethical Approval

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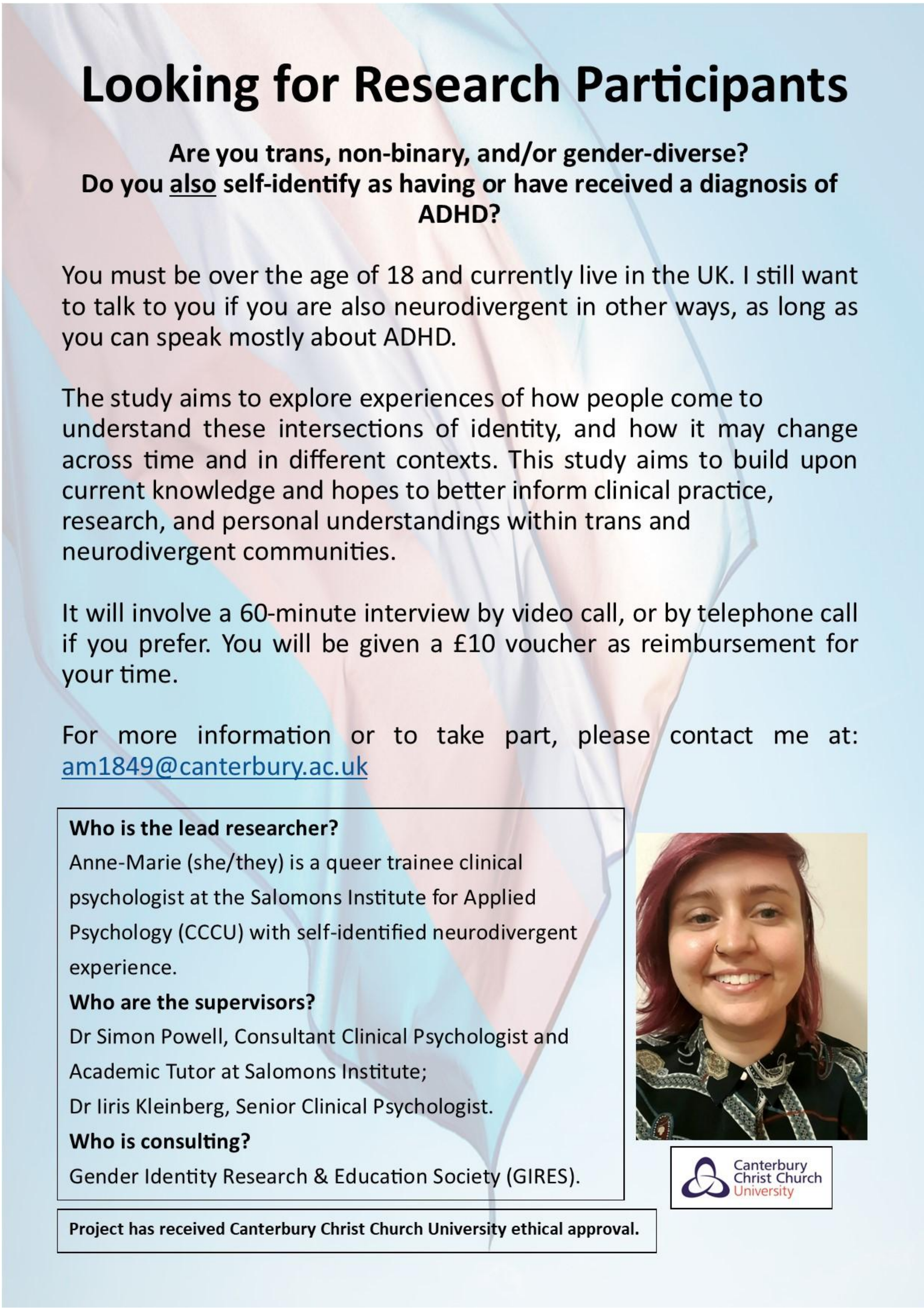
Appendix B: Recruitment poster



Looking for Research Participants

Are you trans, non-binary, and/or gender-diverse?
Do you also self-identify as having or have received a diagnosis of ADHD?

You must be over the age of 18 and currently live in the UK. I still want to talk to you if you are also neurodivergent in other ways, as long as you can speak mostly about ADHD.

The study aims to explore experiences of how people come to understand these intersections of identity, and how it may change across time and in different contexts. This study aims to build upon current knowledge and hopes to better inform clinical practice, research, and personal understandings within trans and neurodivergent communities.

It will involve a 60-minute interview by video call, or by telephone call if you prefer. You will be given a £10 voucher as reimbursement for your time.

For more information or to take part, please contact me at: am1849@canterbury.ac.uk

Who is the lead researcher?
Anne-Marie (she/they) is a queer trainee clinical psychologist at the Salomons Institute for Applied Psychology (CCCU) with self-identified neurodivergent experience.

Who are the supervisors?
Dr Simon Powell, Consultant Clinical Psychologist and Academic Tutor at Salomons Institute;
Dr Iiris Kleinberg, Senior Clinical Psychologist.

Who is consulting?
Gender Identity Research & Education Society (GIRES).

Canterbury
Christ Church
University

Project has received Canterbury Christ Church University ethical approval.

Appendix C: Information sheet and consent form

INFORMATION SHEET

The lived experiences of transgender and gender-diverse adults with ADHD

Introduction

Hi, my name is Anne-Marie Martin (she/they) and I am a queer trainee clinical psychologist at the Salomons Institute for Applied Psychology. My supervisors for the project are Dr Simon Powell, Consultant Clinical Psychologist and Academic Tutor at Salomons Institute, and Dr Iiris Kleinberg, Senior Clinical Psychologist.

I would like to invite you to take part in our research study. As part of the ethical procedures for academic research within UK universities, I am providing you with information about the interview process and how the information will be used and stored. **Could you please read this information sheet and sign the consent form electronically.**

Please note in this information sheet I have used the terms 'transgender and gender-diverse' and 'having/living with ADHD'. If you agree to complete the interview, I will ask you about how you prefer to name your gender identity and your experiences with ADHD. I will also ask you general demographic information.

Rationale and benefits to taking part

Current research has suggested that people with ADHD are more likely to be transgender or gender diverse than people without ADHD (and vice versa). This study aims to explore your experiences and how you make sense of being transgender/gender-diverse and having ADHD. I hope you also find it interesting to share your experiences.

I would like to interview you online to hear about your experiences. The interview will ask you open questions to explore your experiences including how your view of yourself has developed over time, how you found yourself relating to others, the types of responses you have received from others, and anything else you think it would be helpful for us to know.

Can I take part?

We would like you to take part if you are an adult (18 years old and above), live in the UK, self-disclose that you have self-identify or have received a diagnosis of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD) and consider yourself to be transgender or gender-diverse, which includes but is not limited to non-binary, genderqueer and genderfluid identities.

Ideally the interview would be conducted online over MS Teams or Zoom, so you would need access to some form of technology with a microphone and camera such as laptop or smartphone. When we arrange the interview, I will discuss whether this is accessible and feels comfortable for you, and we can decide whether another online call platform, camera off at the beginning or throughout, or telephone call would be a better fit for you.

Disadvantages to taking part

We do not anticipate there will be any risks for you taking part in the study, though there is the possibility that some questions touch upon sensitive topics and bring up feelings for you, for example asking about how others have responded to your identity. As a trainee clinical psychologist I will help you manage this during the interview. At the beginning of the interview we will talk about how you can look after yourself, how you can look after your feelings, and who you could seek support from (such as friends, family, support lines or NHS crisis or CMHT services if you are supported by one). I will also provide everyone with contact details for support services should you feel you need them, which we can discuss together.

Consent

Should you agree to being interviewed, I will arrange a time that is convenient for you and the interview would last 60 minutes. You have the right to stop the interview at any time and you do not have to answer a question if it makes you feel uncomfortable (and do not need to give a reason for not answering).

You have the right to withdraw your consent to completing the study at any point prior to and during the interview. All information gathered from you over the course of the study would be destroyed. You can withdraw your consent afterwards in the following two weeks after our interview.

Data Protection

The interview will be conducted via an audio-visual platform. Preferably we would use Zoom with both of our cameras on, however we will have opportunity to discuss over email adaptations you may need such as other platforms, no camera in the beginning or at all during the interview, or telephone call.

The interview will be recorded through Zoom recording and transferred to secure, private online storage. The audio will be transcribed into written text and stored on encrypted USB, and the recording then destroyed. To keep your information confidential (so that it is not shared with others) information that could identify you (such as names and locations) will be changed, making the written text anonymised to everyone except myself and Dr Simon Powell. Only myself (as research investigator) and my supervisor Dr Simon Powell will have access to the full transcripts. The data are stored in the Salomons Institute’s office in a locked cabinet for 10 years and then destroyed.

Confidentiality would only be broken if I felt there was a risk of harm to yourself or anybody else by not sharing the information, though I would endeavour to inform you about this and discuss this with you before I would reach out to inform supporting services.

Transcript Enquiries and Transparency

Please do let me know if you would like a copy of your transcript. You can also let me know if you wish to retract from the transcript any information you shared. The information about you and from your interview will be stored securely and following ethical and legal practice from Salomons Research Ethics Committee standards. This study has been reviewed by them to keep you and your information safe.

The interview transcripts from yourself and other participants are analysed to develop codes and then a model to understand things that impact transgender/gender diverse adults with ADHD. The research will be written up as part of my thesis, and direct quotes (with identifying details removed or altered in a way that minimises impact upon meaning) are used to highlight the findings. I will ask you for a pseudonym (false name) you would like me to use for you. Quotes are used from across participants. I will contact you to confirm if you consent to me using the anonymised quote(s) in the write-up of the research – you have the right to request that I do not use the quote(s). I will share the results of the study with you and I hope to publish this research in the future to a journal such as Transgender Health which is peer reviewed and open access (available at no cost and anyone can access it online).

Payment

You will receive £10 in compensation for your time and sharing your expertise. The £10 is given in the form of an Amazon or VEX multipay voucher https://www.voucherexpress.co.uk/content/vex-gift-card-where-to-spend.aspx

Your email and first name will be securely sent to the Canterbury Christ Church University finance department who will arrange your voucher; your email would not be used for any other purpose.

Any Further Queries?

Any variation of the conditions above will only occur with your further explicit approval. Please know you can contact me or Dr Simon Powell at **simon.powell@canterbury.ac.uk** at any point if you have any questions, concerns or comments about the study.

Complaints

Please do contact me or Dr Simon Powell if you are unhappy with any aspect of the study, interview, or feel you have been harmed. If you are unsatisfied with our responses, you can contact Dr Fergal Jones, Research Director, at Salomons Institute for Applied Psychology at **fergal.jones@canterbury.ac.uk.**

CONSENT FORM

Title of study: The lived experiences of gender-diverse adults with ADHD

Researcher Name: Anne-Marie Martin (she/they)

Supervisors: Dr Simon Powell, Consultant Clinical Psychologist and Academic Tutor at Salomons Institute; Dr Iiris Kleinberg, Senior Clinical Psychologist.

Please mark each ☐ to indicate that you have read the Information Sheet and agree to take part in the research, including:

- I understand that I have the **choice** to take part in this study ☐
- I understand that **I can withdraw** from the study prior to interview, **I can stop the interview** at any time, **I can decline to answer any question** without giving a reason, and **I can withdraw my consent in the two weeks following** the interview ☐
- I am aware that the interview will be conducted over **an audio-visual platform such as Zoom** (though we may agree telephone for accessibility/comfort) and recorded. I understand that the **recording will be transcribed** and the **recording destroyed** ☐
- I understand that **the information and data** I provide will **be treated confidentially** and **stored securely** ☐
- I am aware that my **anonymity will be maintained** and I will be asked to **choose a pseudonym (false name**) for the written thesis. I am aware that no personal or identifying details will be included in the written thesis or any potential submission to journals in the future ☐
- I am aware that I will be contacted to **confirm agreement for anonymised quote(s)** chosen to be included in the report ☐
- I am aware I **can request a copy of my transcript** and **can retract any details** ☐
- I understand that I **can contact Anne-Marie Martin** or her Salomons supervisor **Dr Simon Powell** at any time **if I have any queries or I am unsatisfied** with the conduct of the study. I am aware I **can contact Dr Fergal Jones**, Research Director, at Salomons Institute for Applied Psychology at fergal.jones@canterbury.ac.uk if I remain **unsatisfied with the response to any complaint** about the conduct of the study ☐
- I am aware that I will **receive £10 compensation** for my time and expertise, in the form of an Amazon or VEX multi-pay voucher. My email and first-name will be sent to the Canterbury Christ Church University Finance Department to process this, securely ☐
- I have had the **opportunity to consider the information, ask questions** should I wish, and I am satisfied by the responses I have received ☐

By signing you confirm that you agree with the procedures and use of your information, and you consent to take part in this study.

Please sign this consent form electronically by including your name and signature below, and return the form to me.

Alternatively if you do not have a signature you can include, please email me with your completed form (except for signature) and include the statement “I understand and agree with the procedures of the study and use of my information. I consent to taking part in the study”.

Participant Name and Pronouns:

Participant Signature:

Date:

Appendix D: Interview schedule

INTERVIEW SCHEDULE – UPDATED/SELECTIVE SAMPLING

Note: Participants to be asked about their pronouns and preferred terms to be used for each question (e.g.) having ADHD, being ADHD, ADHD-er, being neurodivergent, etc. Similarly for gender and how you would prefer me to describe your gender within this study**.**

Introductions and what to expect

- Check participant in a private and comfortable space **with suitable** connection. Explain what I will do if my or their internet or technology have issues (e.g.) wait a few minutes to reconnect, contact via email.
- Introductions and discuss pronouns and preferred terms as above, ask and provide answers if there were any questions or concerns from the information sheet.
- Reiterate their right to not answer particular questions or stop the interview, and reiterate they do not need to give any reason
- Acknowledge that some of the questions may cause discomfort or elicit emotions. Discuss any coping strategies that they have and could use following the interview should this come up for them, and any people they could seek out if they are distressed**. Explain about debrief and signposting resources sent to all participants.**
- I'll check in with you if I think something has brought up difficult feelings, and you can also let me know. I'll ask if you'd like a break at the halfway point, let me know if you need additional breaks before or after this.
- This is your space– some people find it helpful to fidget or use something like a fidget-cube
- I will use a pseudonym (false name for you) to represent your experiences and a quote in the written thesis. **I will email you afterwards to provide me with two or three potential pseudonyms (in case other participants have chosen the same one). I also have a demographic information form which I would like you to complete.**

ADHD (use language as per participant preference e.g. have ADHD, an ADHDer, neurodivergent)

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1. Could you tell me about what ADHD/being neurodivergent means to you?
Prompts if needed: how have you come to learn about **ADHD**? How does it affect you and your day-to-day life? What works well for you?

2. Can you tell me when you received your diagnosis of ADHD or came to self-identify with ADHD?
Prompt: If diagnosis received in childhood, how did you experience the process of diagnosis and support. If received in adulthood or not yet, can you say some more about your experiences of this. Does ADHD feel it 'fits' for you?

3. Has your understanding or sense making of ADHD/being neurodivergent changed over time? How has it changed?

Prompt: some research literature, as well as some other participants in this research describe**d** changing their behaviour around other people. Is this relatable?

Gender

4. Could you tell me about your experiences with your gender over time.

5. Do you have any particular feelings about (use as appropriate for participant) being transgender/non-binary/gender-diverse?
Prompt: would you describe it as an important part of who you are?

Nexus of identities

6. Research and online communities suggest that neurodivergence and LGTBQ identities may be associated with one another, and in this case trans/gender diverse identities and having/being ADHD. What do you make of that?

7. Are there ways in which your ADHD and gender are connected or interact with each other?
Prompt: Other participants have spoken about: sense of being own person or rejecting social norms, different emotional intensity, sense of time in short and long-term.
Challenges: Some ideas that have come up are: talks about difficulty communicating who you are to others, sense of time and waiting, shame and rejection sensitivity, sense of justice.

8. ***(If has not arisen already through previous responses)*** Are there different places, people or contexts that affect how much you think about or share these aspects of yourself with others? Could you tell me more about that.
Prompt: Such as school/university, clinical appointments, with friends, on the internet.

9. Do you know other people who are trans/gender diverse and have ADHD? Online or in-person. What do you make of that?
Prompt: How did you get to know each other?

10. [If not already covered earlier in ADHD section] Have you had any experiences of people making assumptions about your ADHD based upon your gender (for example as a child)?

11. What things, people, resources have you/do you draw upon for your wellbeing?
E.g. books, community, spirituality, etc.

12. Is there anything else you think people should know about having ADHD and being *transgender/gender diverse*?

Reflections

13. Lastly so I can check in and keep improving, how have you found the whole process so far of being opting into the study and the interview today? Are there any questions that you found frustrating to be asked or not asked? Any changes or adaptations that you think I could make going forwards? Anything you would like to ask me?

Appendix E: Signposting document

Thank you for taking part in the interview and research process. I have included the resources for support or simply to find out more about ADHD and gender.

ADHD

- **ADHD UK provide information about ADHD including a diagnosis pathway for those who may be seeking an ADHD diagnosis, and online support groups**
- **ADHD Foundation - The Neurodiversity Charity provide an integrated health and education service, including resources and webinars for people with ADHD and for professionals working with ADHD and neurodiversity.**
- **ADHD Aware is a small Brighton-based peer-support charity who offer information resources and online support groups nationally.**
- **Additude mag has information including short online articles and webinars about ADHD.**

Gender

- **Gendered Intelligence are a trans-led and trans-involving grassroots organisation. They also operate a support line via telephone, email or WhatsApp service for those who need information and emotional support while waiting for gender affirmative healthcare.**
- **The Switchboard LGBT+ helpline provide a telephone, online chat or email service for information, emotional support, and signposting including for therapy and social groups.**
- **The LGBT foundation offer advice, support and information on their website and phoneline. They also offer direct services in the Manchester and Greater Manchester area.**
- **Spectra promote the good health and wellbeing of LGBTQ communities. They are London based but their trans services include information and online trans social groups, online peer mentoring, and online workshops.**

Mental Health

- **The Mind website has links to a number of different telephone, email or webchat services, including the Samaritans if you need support and listening services in the UK.**

- **Mindline Trans+ is a UK wide service offering a confidential emotional, mental health support helpline for people who identify as trans, agender, genderfluid or non-binary. Currently due to volunteer levels this is service is only available on Friday evenings.**

  They also support family members and friends, and can provide signposting to other services and resources. Trained listeners identify as trans, non-binary or gender fluid. They are understanding and will listen and offer support. Occasionally cisgender allies may also take calls. This is a UK wide service, delivered by Mind Somerset.

  Phone 0300 330 5468
  Email Mindline@mindinSomerset.org.uk
  Website https://www.mindinsomerset.org.uk/our-services/adult-one-to-one-support/mindline-trans/
  Opening Hours Friday 8pm-11pm

If you feel distressed following our interview, you can:

- **Contact NHS 111 if you live in England**
- **Contact NHS 111 or NHS Direct (0845 46 47) if you live in Wales**
- **Contact NHS 24 on 111 if you live in Scotland**
- **Contact your GP surgery and ask for an emergency appointment.**
- **For services in Northern Ireland, please see https://www.nidirect.gov.uk/articles/mental-health-emergency-if-youre-crisis-or-despair and the zero suicide alliance website**

The Mind website also has practical advice to help you cope in a crisis.

If you need help in a crisis, have seriously harmed yourself or feel like you might attempt suicide please:

- Call 999 for an ambulance
- Go straight to A&E, if you can
- If you are supported by a crisis team, please call them - if you don't already have their number, you can find an urgent mental health helpline on the NHS website

Appendix F: Exported NVivo Codes from axial coding

Note: Organised to aid thinking

Name	Files	References
ADHD and environments	2	2
ADHD and education	0	0
ADHD and gender presentation in school	8	15
ADHD and higher education	4	7
Being able to leave things until the last minute, until this doesn’t work	2	3
School as a place of struggle and difference	8	20
ADHD and work	0	0
Mental health settings experience	2	3
More positive than education	4	5
Trying to take on too much at work	1	3
ADHD as way of being that has tensions with western society	6	10
ADHD still being a difficulty even with ND paradigm or movement	2	4
Managing societal expectations	4	5
ADHD and neurodivergence as community and connection	6	10
Being drawn to others who are also ND	4	10
ND in the family or household	4	12
Clinicians searching for causes	2	4
Feeling doubly misunderstood or overlooked	2	2
Community knowledge not known or represented in healthcare	1	4
Development of collective knowledge, understanding, and communication	2	4
Not fitting into 'neurotypical' in-person LGBTQ spaces	2	2
'It was like I was able to connect the dots' - understanding through speaking with others	4	7
Medical or professional knowledge as more trustworthy	1	1
ADHD and neurodivergence through the lens of difficulty or disorder	9	29
Being misunderstood by non-ADHD experiences of attention	5	7
Neurodiversity is not as well known or defined like the disorder	1	1
Not neurodivergent, not disorder, just part of me	2	3
Stigma, shame and rejection	7	30
'Expect bad things to happen'	1	1
Feeling othered	6	14
Behaviours not accepted even in neurodiversity friendly spaces	1	1
Isolating oneself	0	0
In response to societal shame and stigma	4	14
Way of being 'Just not a good fan of people'	4	4
Masking	2	2
Resisting or not experiencing shame	7	29
Stigma from clinicians and therapists	3	7
Weighing up validity of info from professionals vs lived experience	3	3
ADHD and trans or gender diversity as more likely co-occurrence	0	0
'Already questioning on a deeper level'	6	7
ADHD and gender are not associated	2	4
'I can't really divide them'	4	11
'Live life to please yourself, not society, not anyone else.'	7	22
Freedom and openness	3	14
'I was already being clocked' - not a choice to 'come out'	2	3
Questioning enforced gender rules	5	11
ADHD and trans or gender diversity intersection	6	16
ADHD traits interacting with transition	0	0
ADHD mannerisms that are gender dysphoric	2	2

Impulsivity with significant decisions	2	2
Things that are both neuro and gender affirming	1	1
ADHD understood better than gender diversity	3	4
Being subject to gendered understanding of ADHD	8	27
MH diagnoses before ADHD	4	5
Embodiment and comfort in body	2	6
Sensory overstimulation and exploring gender expression	3	5
Executive functioning needed to navigate gendered healthcare	3	6
Forgetting medication and appointments	3	7
Feeling disconnected to oneself and life prior to realisations	4	8
Having lots of friends also trans and neurodivergent	5	7
Initial distancing or non-identification from ADHD label	4	6
Interactions between hormones and ADHD traits	5	14
Searching for information	10	30
Caught unaware about transition effects	2	3
Searching for others to speak to online	8	19
Social media communities and representations of ADHD	7	10
Takes time to consider ADHD	3	9
The need for shared experiences, like case studies, not diagnosis criteria	4	6
Understanding gender	3	7
Not allowing others to tell you who you are	5	11
Realising one's differences from common gender narratives	2	4
Shame	1	1
Temporality in the lifespan. Queer time	6	23
Hope from evolution in understanding and acceptance with each generation	2	6
Wanting transition to be done 'now' and 'right'	2	5
'What I felt inside was absolutely different from what people perceived about me'	2	3
ADHD Strategies and Interventions for Distress	4	4
Developing and realising own ways of managing demands	10	23
'Making mental accommodations for myself'	1	2
Managing mood and mental wellbeing	1	3
Doing physical activity	4	4
Explaining your perspectives and ways of being to others	3	3
Feeling supported and safe in your environment	4	10
Medication - making individual choice in starting and continuing	9	11
Mental Health	4	21
pushing away others' judgements and or own emotional responses	5	8
Therapies and psychological	7	15
When others understand	5	17
Characteristics of ADHD	2	3
Emotions	9	19
'Like the champagne bottle' - emotional intensity	4	6
Regulating them	5	7
Isolating self to protect emotions	2	3
Executive functioning	3	4
Brain moving very quickly	6	8
Drive or need to be doing things	5	11
Needing the right amount of stimulation	5	12
Talking a lot	2	4
Impulsivity	4	4
Making choices	2	5
Motivation and initiation	5	8
Need for routine and reminders	4	7
Needing to direct one's attention	1	1

Holding self to high standards	4	5
Hyperfocus	9	20
'Injustice just really sets you off'	5	5
Interests and passions	7	12
Maintaining interest	5	9
Not receiving bodily signals for hunger	3	3
Overlap with autism	3	5
Fear around misidentification as emotionally unstable personality disorder	2	2
Rejection of norms or societal expectations	6	15
Rejection sensitivity	3	5
Thinking outside of the box and creativity	6	10
Gender	0	0
Choosing when, where, and with whom to disclose	4	4
Coming out as a process	3	3
'it floats around the back of my mind for ages and ages'	2	2
Difficulties in childhood	3	5
Gender being read differently by others, from childhood	7	17
Feeling alone, misunderstood	4	6
Household difficulties	3	9
Influence of the Church	2	4
Gender affirmation	6	8
Seek feeling better in oneself, not alleviating distress	2	2
Gender Dysphoria	6	10
Ambient or background	1	1
Being pressured growing up to act in a gendered way	7	11
Dysphoria experienced only when looking back after bodily changes	1	1
Grappling with internalised misogyny or toxic masculinity	3	4
Non-binary labels as not quite satisfactory	5	11
Being doubly discriminated non-binary and bisexual	2	7
Internalised stigma	2	3
Navigating dominant binary views of gender including transition	6	15
'Non-binary is easier' 'is most practical' for others to understand	4	4
Stigma that it is a 'cool trendy things that the kids are doing now'	1	3
Understanding as a child 'I'm not a girl and not a boy'	2	3
Stigma	1	3
from media	1	1
from other authority like religion	1	2
from professionals or healthcare	3	7
Understanding trans as an identity by getting to know trans people	4	9
Exposure to new ways of being or possibilities	1	1
Identification	0	0
Deciding whether want to seek diagnosis, and the timing	7	9
Clinicians and services having power over you	5	13
Validity of your diagnosis	0	0
Diagnosis after diagnosis of other condition associated with ADHD	1	2
Increases in diagnoses in popular media or discourse	2	3
Self-defining ADHD vs formal diagnosis	3	7
Feeling that would have benefited from earlier recognition of ADHD	4	6
Wider, other people's awareness and knowledge of ADHD and ND	3	6
Masking delaying self and others realisation	3	3
Others suggesting ADHD to you	2	6
Sought out by parent	3	7
Function of ADHD label	6	12
ADHD as a name needs updating	4	6
'Allows others to understand on a deeper level'	2	2

Process to 'have a lot more empathy for myself'	8	29
Parallels and differences in identification or diagnostic processes	2	9
Being questioned for long term evidence as validity	1	5
Greater felt gravity of trans identity exploration	1	1
Services are not joined up or interact with each other	2	5
Trans or GD identity dismissed or pathologised due to ND	3	7
'They were both before and after moments in my life'	8	19
ADHD diagnosis doesn't solve everything	1	1
What is identity	7	14
Gender	6	11
Wish to escape labels	1	2
Identity 'born through experience' and what 'has been done to them'	2	4
Temporality	0	0
Changes in self-imposed pressure and wider awareness with age	1	4
'It hasn't changed over time. It has stayed the same'. Settled on a label	2	2
'There's a lot left to experience' - fluidity and openess to change	4	5
Knowledge	0	0
Epistemic and hermeneutic injustice	0	0
'I didn't have the right words'	1	1
'Imagine if I'd heard the word non-binary back then' - possibilities	1	1
Knowledge as 'joint creation of understandings'	1	1
'Only for someone else to say, I know you better than you know yourself'	2	2
Gender, feminism and human rights	5	13
Being drawn to trans rights before self identification	3	4
having to be the 'gender warrior'	1	1
‘I went to Google’	2	4
Understanding ADHD and neurodiversity as a different way of being, mind working	5	9
Awareness of need for structural understanding and support	2	5
Frustration that other forms ND 'left out of the conversation'	1	1
'Going back and forth' with medical and ND understandings	3	9
Using biological understandings for validity	4	10
Trauma and adaptive responses	7	17
Anger	5	14
Hypervigilance	6	9

Appendix G: Example application of Conditional/Consequential Matrix

Matrix Step	Definition	Example
a) Context	The micro and macro level conditions indicated within the data.	School system, as part of wider financial system, that praises and rewards performance in particular topics that are easily applied to salaried jobs.
b) Conditions	The situation or happenings that the individual (or group) experiences, including the available resources to them such as personal ability, motivation, knowledge, and support.	Receiving feedback and labelling about lack of effort or ability to complete assigned work *"lazy" "stupid"*. Being left behind or overlooked in school and/or higher education, or being supported and encouraged. "*I'm just left to my own devices at school and obviously massively struggling with it."* Personal ability to engage with the work, when supported: *"But when people are explaining stuff to me and taking the time to explain stuff, I get it and like can do well…I then had to go back to do an access course…where I got basically all*

		distinctions, while one merit…I would put that down to I had a really fantastic personal tutor who really took the time and kind of explained it to me in ways that I just got."
c) Action-Interactions	The meaning-making of individuals in response to the conditions, including emotions and thoughts. For example, whether the condition is that it is a problem, challenge, something to be managed, or a goal.	Internalisation as being "stupid" in the education system. Anger looking back at treatment received. Viewed as a problem, located partially in the self and also within the wider context. Problem to be overcome is continued engagement in higher education and/or the workplace. *"so for me, it's hard to not be quite negative about that to think, well, actually, you know, people keep interpreting the way I am in these contexts and within the world, as somebody who is just stupid and so I think for a long time, I was very resentful of that"*

d) Consequences	The consequences that the individual (or group) that are desired or to be avoided, and whether the consequence is anticipated or not. These can be physical, psychological or social. Consequences in turn can generate emotions and meaning-making, and so change the direction of Action-Interactions or spur new ones.	Desired and actual consequence of good performance at work/education. Spurs on further action-interaction of higher education. Additional consequence of realisation of own's ability, and being defined as "stupid" is no longer static/stuck. *"until now - I have the correct support in place, obviously from partner, from teachers, from friends who understand for whatever reason, and then end up doing really well. So I think it just goes to show if you're given the right resources.*

Appendix H: Example research memos and diagrams for category development

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Appendix I: Abridged research diary

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Appendix J: End of study notification letter

Interactions in identity development in trans and gender-diverse adults with ADHD: an abbreviated grounded theory design

Research and clinical conceptualisations of attention deficit hyperactivity disorder (ADHD) has historically been based upon observation of cisgender boys (Holthe & Langvik, 2017) which has contributed to the potential late recognition or dismissal of ADHD in girls and women (Young et al., 2020). Recent research suggests an association between being transgender or gender-diverse (TGD) and ADHD (Strang et al., 2018). However systematic review by Goetz and Adams (2022) highlights the paucity of research that has explored this; the research available has predominantly explored prevalence, and the limited inclusion of case studies has been deficit-focussed. This reflected a significant literature gap for exploring this intersection using a qualitative methodology, and an abbreviated grounded theory methodology (Corbin & Strauss, 2015) was indicated due to the lack of research in this area. The study was also rooted in the neurodiversity paradigm, a perspective that views neurological differences as natural variations in human experience rather than deficits or disorders (Walker, 2021).

Participants were included if they were adults (18+ years) living in the UK, self-identified as transgender, non-binary, or gender-diverse (TGD), and disclosed having ADHD as their primary neurodivergent experience. They needed access to digital technology for online interviews. Exclusion criteria included individuals with conditions or experiences unrelated to ADHD or those unable to participate in an online interview format.

Semi-structured interviews with 11 UK-based participants were completed, with participants aged 21-56 years old and with a diverse representation of ethnicities and gender identities. Most participants had received a diagnosis of ADHD.

Analysis generated a tentative model with four categories, where findings indicated the application of existing theories and concepts of into two categories: stigma and shame, and trauma. In addition to these two categories, two other categories were developed which were integral to identity development: available knowledge and temporality. Within the category of knowledge, access to language and to community were theorised as potential ways to alleviate internalised stigma, shame, and the effects of trauma. These processes influenced the mental wellbeing of participants. The findings were within the wider macro-level contexts that participants spoke to, including the influence of neoliberalism in the education system and workplace, gender norms, and healthcare systems that seek validation of diagnosis through longitudinal evidence or narratives.

This research addresses a significant gap in literature, reframing ADHD and TGD identities within an empowerment-focused lens which highlights the potential oppressive forces of societal structures, while underscoring the importance of addressing stigma and trauma in clinical practice, such as through more nuanced application of the including the application of the minority stress model.

Appendix K: Journal submission guidelines

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Appendix L: Example Coded Transcript

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