

Beyond the Diagnosis

Reframing Adult ADHD in a Psychotherapeutic and Sociocultural Context

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Certainly there are very real differences between us of race, age, and sex. But it is not those differences between us that are separating us. It is rather our refusal to recognize those differences, and to examine the distortions which result from our misnaming them and their effects upon human behavior and expectation.

- Audre Lorde, *Sister Outsider* (1984/2007, p. 107)

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ABSTRACT

This thesis interrogates how adult Attention-Deficit/Hyperactivity Disorder (ADHD) is defined, experienced, and treated within contemporary culture, with the aim of developing a relational, neurodiversity-informed, and neurodivergent-affirming psychotherapeutic framework. It explores how dominant narratives continue to pathologise attentional difference while obscuring the roles of stigma, shame, and emotional dysregulation. Drawing on academic literature, diagnostic manuals, memoirs, and podcasts, the study critiques deficit-based models and centres lived experience. The methodology integrates Foucauldian discourse analysis, Lacanian psychoanalysis, and perspectives from the neurodiversity paradigm to examine discursive power, affect, and identity. Findings highlight how ADHD is shaped by sociocultural forces, intersectional exclusions, and internalised norms around productivity and self-control. The study concludes by proposing inclusive clinical adaptations grounded in co-regulation, pacing, and mentalization, repositioning therapy away from behavioural correction and towards attuned, identity-affirming engagement and ethical responsiveness.

CHAPTER ONE: Introduction

1.1 Study Background

“Perhaps the most difficult thing that a human being is called upon to face is long, concentrated thinking” (Gernsback, 1925, as cited in Wythoff, 2016, p. 284). This observation, made nearly a century ago, captured Gernsback’s frustration with the endless distractions that derail focus, from external noise to the wanderings of one’s own mind. In an attempt to manage this, he created the “Isolator,” a helmet designed to eliminate auditory and visual stimuli, allowing the wearer to focus solely on the task at hand (Gernsback, 1925, as cited in Wythoff, 2016, p. 284). While seemingly extreme, the invention reflects a longstanding cultural preoccupation with managing cognition, particularly in relation to attention and distraction. It invites a deeper inquiry: what constitutes distraction, and why are certain attentional styles pathologised while others are celebrated?

In this thesis, *attentional* is used in expressions such as *attentional styles*, *differences*, *wanderings*, and *divergence*, to refer to the diverse ways individuals focus, shift, or sustain mental engagement across contexts. This framing draws from neurodiversity-informed literature (Walker, 2021, pp. 16–18) and critiques of normative cognition (North, 2011; Yergeau, 2018), which suggest that so-called inattentiveness may not indicate dysfunction, but alternative modes of processing shaped by cultural and institutional norms. As Walker (2021) observes, the dominant pathology paradigm assumes that:

There is one ‘right,’ ‘normal,’ or ‘healthy’ way for human brains and human minds to be configured and to function... [and] if your neurological configuration and functioning (and, as a result, your ways of thinking and

behaving) diverge substantially from the dominant standard of ‘normal,’
then there is *Something Wrong With You* (p. 17).

From this perspective, distraction may be understood as a legitimate cognitive variation, one that can foster creativity, divergent thinking, and novel engagement with the world.

This rethinking of distraction and focus can be understood within broader debates about Attention-Deficit/Hyperactivity Disorder (ADHD). North (2011, pp. 1–16) similarly reframes distraction as an alternative mode of thought, one that resists disciplinary control. Yet within dominant psychiatric discourse, attentional wandering is routinely medicalised, particularly through the diagnosis of ADHD. In contrast to deficit-based framings, Hallowell and Ratey (2021) describe the ADHD mind as having “the power of a Ferrari engine but with bicycle-strength brakes” (p. 5), a metaphor that emphasises challenges of modulation more than evidence of pathology. Supporting this view, empirical work with adolescents finds above-average divergent-thinking scores in ADHD samples (Abraham et al., 2006), highlighting the creative potential of attentional variability. While distraction is often seen as a failure of self-discipline (Crawford, 2015, pp. 3–5), it may also represent a meaningful form of engagement with the world. Furthermore, Berlant (2011, pp. 5–8) notes that cultural ideals of constant productivity can give rise to cruel attachments, where distraction is read as a moral failure rather than a response to structural demands.

This tension is also critiqued by Lloyd (2025), who highlights how hyperactivity is seen as a strength in some domains and a disorder in others. “For adults in the workplace, being hyperactive is a real asset and seen as a strength... whereas in a classroom it's a disorder” (Lloyd,

2025, 5:28). He further points to the impact of stigma, describing widespread “myth and stigma and misunderstanding and ignorance and shame” as unjust and deeply damaging (2:03–2:16).

To fully understand the implications of these contradictions, it is necessary to examine the role of stigma in shaping the ADHD narrative. Stigma is central to understanding ADHD as both a clinical category and lived experience. Link and Phelan (2001) define stigma as involving “labelling, stereotyping, separation, status loss, and discrimination, within a power dynamic” (as cited in Flanigan, 2021, p. 13). The effects can include “decreased self-esteem, social withdrawal, and treatment avoidance” (Flanigan, 2021, p. 1). These experiences are compounded in adulthood, where misunderstanding and shame persist despite growing recognition of adult ADHD.

Yet in many clinical settings, ADHD remains framed through a biomedical lens, privileging pharmacological and behavioural interventions (Asherson et al., 2016, p. 569). Such approaches often overlook the emotional complexities of ADHD, including shame, rejection sensitivity, and affect regulation (Hinshaw et al., 2021; Mowlem et al., 2019). For many adults, ADHD is not simply a clinical diagnosis but a lived and often marginalised identity shaped by stigma, gendered expectations, and systemic exclusion (McCabe, 2024; Khorsandi, 2023). Within psychotherapy, especially where biomedical understandings are uncritically adopted, there can be a tendency to frame ADHD primarily in terms of behavioural symptoms or failures in self-regulation (Barkley, 2015, pp. 71–72). Salomonsson (2017), by contrast, situates ADHD within the transference, understood here as the unconscious repetition of early relational patterns in the therapeutic relationship. He explores how hyperactivity and impulsivity may reflect deeper anxieties, faltering semiotic capacity, and difficulties with affect modulation.

1.2 Methodological Approach

This research employs a critical, interdisciplinary, and theoretical qualitative methodology, synthesising peer-reviewed literature, autobiographical texts, podcast narratives, and expert commentary. Sources from psychiatry, psychotherapy, disability studies, education, feminist theory, and sociology were reviewed using databases such as JSTOR, PsycINFO, Google Scholar, SAGE Journals, and EBSCO Discovery. Selection prioritised recent publications (within the last decade), complemented by foundational texts where necessary.

1.2.1 Critical Theoretical Framework

Working from a critical social-psychoanalytic lens, this study draws on three complementary traditions to examine how adult ADHD is constructed, lived, and addressed in therapy. Foucauldian discourse analysis maps the power/knowledge arrangements that shape diagnostic language and institutional structures (Foucault, 1977, 1980). Lacanian psychoanalysis focuses on micro-level processes of desire, shame, and symbolic formation in the therapy room (Lacan, 2002). The neurodiversity paradigm, meanwhile, offers an ethical stance, reframing ADHD as a valid form of human variation rather than a deficit (Walker, 2021; Chapman, 2021; Kapp, 2020; Yergeau, 2018). Chapman (2021) describes neurocognitive diversity as “a normal and healthy manifestation of biodiversity” (p. 1361) and calls for relational understandings of functioning (p. 1363). Kapp (2020) outlines the movement’s scientific and political goals, including stigma dismantling and empowerment. Walker (2021) and Yergeau (2018) further argue for the centrality of cultural narratives in shaping neurodivergent identity.

This approach aligns with Kincheloe’s (2001) concept of critical bricolage, which advocates for theoretical multiplicity and sociopolitical awareness. Kincheloe emphasises the

importance of drawing on diverse sources and resisting disciplinary constraints in order to expose “the historicity of certified modes of knowledge production” (p. 681). Similarly, St. Pierre (2024) views qualitative research as historically and politically situated, shaped by interpretive communities and researcher positionality.

Yergeau’s (2018) analysis of neurotypical norms culturally inscribed onto neurodivergent bodies informs this methodology, notably given high comorbidity rates between autism and ADHD (Leitner, 2014; Antshel et al., 2013). She argues that neurotypicality is a socially dominant orientation rather than a neutral standard, underscoring the imperative to interrogate not only diagnostic categories but the discursive assumptions that shape how ADHD is researched, narrated, and understood.

1.2.2 Epistemological Position and Terminological Reflexivity

The methodology is underpinned by a constructionist epistemology, treating knowledge about ADHD not as objective truth but as shaped through discursive and cultural processes. Drawing on Foucault’s (1977, 1980) theory of discourse and disciplinary power, this study considers ADHD not simply as a medical label but as a product of institutional and cultural mechanisms. Diagnosis is conceptualised as participating in the regulation of subjectivity and behaviour, operating through subtle norms of observation, categorisation, and correction. As Foucault (1980) describes, disciplinary power functions through “a tightly knit grid of material coercions” (p. 104), designed to optimise both the docility and utility of individuals.

Lacanian psychoanalysis adds a distinct layer to this analysis. Lacan (2002) asserts that subjectivity is structured through the Symbolic order, a network of cultural and linguistic codes that precede and shape individual experience (pp. 247–248). From this standpoint, behaviours

linked to ADHD may reflect not executive dysfunction but ruptures in symbolic inscription. The concept of *passage à l'acte*, wherein psychic tension that cannot be symbolically processed is discharged through action, offers a lens to reinterpret impulsivity (Lacan, 2002, pp. 214–217). McCoy (2023) reinforces this interpretation by showing how Lacanian-informed clinicians view hyperactivity and inattention as responses shaped by sociocultural conditions, including capitalist and institutional logics that pathologise non-conforming behaviours (pp. 87, 77, 114).

In parallel, the study draws on the neurodiversity paradigm to emphasise a cultural and political reframing of ADHD as a valid neurocognitive variant, as opposed to a pathological deficit. Neurodiversity scholars and activists argue that terms such as “impairment” or “disorder” reflect medicalised, deficit-based models that marginalise cognitive difference (Chapman, 2021, pp. 1361-1363; Walker, as cited in Kapp, 2020, p. 261). Instead, neurodivergence is positioned within a social ecology that considers not only individual functioning but also relational and group-level contributions to society. This reflects a shift away from narrow biostatistical norms and towards a recognition of dispositional and functional diversity as legitimate and valuable (Chapman, 2021, p. 1363). As Lloyd (2025) reflects, “having some kind of label that doesn’t carry shame and stigma... is important in understanding who I am and how I relate to the world” (12:59–13:11).

To this end, terminology is used reflexively and deliberately. ADHD is treated not as a fixed biomedical fact but as a socially negotiated signifier for a spectrum of attentional, regulatory and affective differences. The label is employed with awareness of its historical contingency and its dual role as both a gateway to support and a potential source of stigma. *Neurodivergence* is used to describe an individual’s atypical cognitive profile, in keeping with

the neurodiversity paradigm that frames differences such as ADHD and autism as natural variants of human cognition (Walker, 2021; Chapman, 2021, p. 1361). By contrast, *neuronormative* designates dominant cultural expectations around productivity, emotional regulation and behavioural control, expectations that marginalise those who diverge from them (Yergeau, 2018, pp. 22–24). Throughout this thesis, therefore, *neurodivergence* refers to individual atypical cognitive styles, whereas *neurodiversity* denotes the broader sociopolitical paradigm that values such variation (Walker, 2021; Chapman, 2021).

These discursive choices acknowledge that language is neither neutral nor fixed. As Chapman (2021) argues, many harms experienced by neurodivergent people stem not from cognitive traits per se but from socially imposed barriers, normative assumptions, and systemic exclusions (pp. 1362–1364). At the same time, many individuals find clinical labels meaningful and even empowering in navigating identity and access to care. As Kapp (2020) notes, the autistic community has “united around the need to protect autistic people’s access to diagnosis because of the practical services and supports medical classification can provide” (p. 9). This study therefore adopts a pluralistic orientation that honours both critical theory and lived experience.

1.2.3 Positionality and Narrative Integration

Given the sociocultural nature of this inquiry, lived experience is treated as a meaningful component of the data. Throughout this thesis, first-person narratives, such as podcasts, autobiographies, and public testimonies, are used to ground theory in lived experience. These accounts illustrate how ADHD is interpreted, narrated, and negotiated in everyday life. Although the study does not include formal interviews, these public personal

narratives offer valuable insights into the affective and interpretive dimensions of ADHD. They are woven throughout the analysis to highlight how individuals articulate affect regulation, masking, and emotional complexity (e.g., McCabe, 2024; Khorsandi, 2023; Lloyd, 2025).

This strategy echoes Braun and Clarke's (2006, p. 81) emphasis on theoretical transparency in qualitative research, highlighting the importance of making one's methodological commitments and interpretive positioning explicit. As Finlay (2002, p. 532) observes, reflexive awareness is integral to qualitative rigour, enabling researchers to critically engage with how knowledge is co-constructed through positionality and relational context. My interpretations are shaped by my intersecting roles as a therapist-in-training, educator, and parent to a neurodivergent child. I also identify with many neurodivergent traits and experiences, which provide an embodied sensitivity to the material under study. These positionalities shape the questions I ask, the sources I privilege, and the meanings I construct.

This study does not seek universal truth, but rather insight that is situated, politically conscious, and theoretically engaged. As Tracy (2010, pp. 840–842) argues, excellent qualitative research prioritises rich rigour, sincerity, and meaningful contribution over aspirations to neutrality or objectivity (pp. 840–842). In this spirit, the methodology affirms that knowledge about ADHD, and mental health more broadly, is always embedded in power, culture, and language.

1.3 Aim and Objectives

This thesis critically examines how adult ADHD is constructed, lived, and responded to within the broader framework of neurodiversity. It draws on critical perspectives that interrogate cultural norms, power structures, and unconscious processes shaping ADHD as both diagnosis and identity. It aims to develop a relational, neurodiversity-informed psychotherapeutic approach that affirms neurodivergent experience while integrating stigma reduction, emotion-regulation science, and intersectional social-justice principles. To achieve this aim, the study pursues two core objectives. First, to analyse how dominant and alternative discourses shape understandings of adult ADHD, including how these narratives reflect or resist gender bias, stigma, and normative expectations. Second, to evaluate how emotional dysregulation is represented in both psychotherapeutic frameworks and public narratives, and to explore its implications for clinical engagement with adult clients.

1.4 Thesis Structure

The chapters that follow are structured thematically to reflect the research aim and objectives. Chapter Two interrogates the classification and medicalisation of ADHD, tracing its diagnostic evolution and comparing Western and non-Western frameworks. Chapter Three analyses stigma and cultural representation, with particular attention to gendered myths and media discourse. Chapter Four turns to psychotherapy, foregrounding emotional dysregulation and evaluating how relational and mentalization-based approaches can meet adult clients' affective and identity needs. Chapter Five synthesises the findings, outlines clinical implications and sets out priorities for future research. Since each chapter ends with its own mini-discussion, the concluding chapter is deliberately concise, while still drawing the strands together.

CHAPTER TWO: The Classification and Medicalisation of ADHD

Diagnostic Frameworks, Discourse, and Global Perspectives

2.1 Framing ADHD: History, Language, and the Politics of Classification

The classification of ADHD has shifted significantly over time, reflecting broader cultural, clinical, and theoretical changes in psychiatry (Barkley, 2006, pp. 3–14). These shifts are embedded in historical, medical, and societal discourses, shaping public perception and individual experience (Druehl & Sporrang, 2020, pp. 1201–1202). This chapter critically examines the conceptual evolution of ADHD, interrogating its diagnostic history, linguistic framing, and the implications of medicalisation.

Layton's (2020) concept of the psychosocial self expands this critique, illustrating how psychiatric classifications shape subjectivity through socio-historical forces rather than purely neurobiological determinants. Although she does not address ADHD specifically, her work offers a valuable lens through which to question whether attentional divergence is inherently pathological or a cognitive style devalued within specific sociocultural contexts. Framing ADHD solely as a neurodevelopmental condition also risks overlooking the economic and political factors that shape which attentional styles are valued or pathologised. Adshead and Horne (2021) challenge dominant clinical models by reframing therapy not as a corrective procedure but as a form of care that must engage with the complexity of individual suffering within social systems. Reflecting on the limitations of forensic psychiatry, they observe that “if supplies are short, you treat the people who have the most chance of getting better” (p. 36), highlighting how diagnosis can function as a resource-driven gatekeeping mechanism. Building on this critique, it can be argued that in such triage-like conditions, diagnosis operates not only as a clinical tool but as a

means of regulating access to care, often shaped by systemic assumptions about treatability, productivity, and recovery potential.

This lens raises a broader question: is ADHD a condition to be corrected, or a lived experience to be supported within an overstretched system? As we explore the evolving terminology surrounding ADHD in the next section, it is crucial to consider how societal perceptions have historically shaped diagnostic frameworks and continue to influence treatment paradigms today.

2.2 Evolving Labels: From Minimal Brain Dysfunction to ADHD

Historically, societal norms have equated focus and productivity with intelligence and competence, positioning alternative attentional styles as deficits to be corrected. North (2011, pp. 1-16) challenges this assumption, arguing that distraction is not necessarily a cognitive failure but rather an alternative mode of engagement with the world. This societal anxiety over distraction has significantly shaped medical discourse, particularly in relation to ADHD. In the mid-20th century, ADHD was initially conceptualised as “minimal brain dysfunction” (Barkley, 2015, p.7), a term rooted in neurological theories that positioned cognitive differences as biological defects. By 1980, the Diagnostic and Statistical Manual of Mental Disorders [DSM] III introduced “attention deficit disorder (ADD)” (Barkley, 2015, p.13), aiming to separate attention difficulties from hyperactivity. However, the DSM-III-R (1987) later reinstated hyperactivity into the classification and renamed the condition attention-deficit hyperactivity disorder (ADHD). This revision reinforced a behavioural framework that prioritised observable symptoms, frequently overlooking the more subjective aspects of cognitive experience (Barkley, 2015, pp. 20–21).

The narrowing of ADHD's definition in the late twentieth century reflected not just technical shifts but broader sociopolitical anxieties about childhood conduct and school discipline (Conrad & Bergey, 2014; Singh, 2011). By foregrounding hyperactivity, these new criteria aligned with institutional expectations of orderliness and productivity, pathologising behaviours that deviated from dominant norms (Timimi & Taylor, 2004). These developments highlight the tension between categorical and dimensional conceptions of psychopathology and have fuelled calls for trans-diagnostic models grounded in underlying neurobiological and behavioural systems (Sonuga-Barke et al., 2016, p. 322).

Amid these debates, Abdelnour et al. (2022) describe how the rise in ADHD diagnoses has sparked ongoing concern over both overdiagnosis and persistent underrecognition, particularly among women and minoritised populations. While shifts in DSM criteria contributed to broader diagnostic capture, they argue that increasing public and professional awareness has also played a significant role, especially in prompting identification of previously overlooked groups. These tensions come into sharper focus when comparing the current diagnostic paradigms. The next section scrutinises how those assumptions are codified in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013) and the International Classification of Diseases (11th ed.; ICD-11; World Health Organization [WHO], 2022).

2.3 Diagnostic Paradigms: DSM-5 vs. ICD-11

The classification of ADHD remains heavily shaped by biomedical models, particularly in what are often termed Western psychiatric frameworks, a designation that typically refers to North American and European systems, though the term itself can obscure important internal

differences and global complexities (Timimi & Taylor, 2004; APA, 2013). The DSM-5 defines ADHD as a neurodevelopmental disorder primarily associated with executive function deficits, inattention, and hyperactivity/impulsivity (APA, 2013, p. 59). It employs a categorical model, classifying ADHD into three subtypes: predominantly inattentive, predominantly hyperactive/impulsive, and combined presentations (APA, 2013, p. 60). This approach reflects a deficit-based model, commonly paired with pharmacological and behavioural interventions as primary treatment strategies (Barkley, 2006, p. 12).

In contrast, the ICD-11 (WHO, 2022) moves towards a dimensional model, acknowledging ADHD traits as existing along a continuum instead of adhering to a strict diagnostic threshold. Unlike the DSM-5, which emphasises observable behavioural symptoms, the ICD-11 integrates contextual and environmental factors into its criteria (WHO, 2022). It describes ADHD as a persistent pattern of inattention and/or hyperactivity-impulsivity that negatively affects an individual's social, academic, or occupational functioning (WHO, 2022). This perspective allows for a more flexible diagnostic approach, considering individual variability and social determinants of attentional differences (Asherson et al., 2016).

While the ICD-11 reflects an effort to move beyond rigid categorical diagnosis, clinical practice remains largely DSM-oriented in many healthcare settings, particularly in North America and Europe (APA, 2013; WHO, 2022; Druedahl & Sporrang, 2020, pp. 1201–1202). However, as Sonuga-Barke et al. (2016, p. 322) note, current psychiatric classifications, including ADHD, are increasingly under scrutiny, with growing support for dimensional and transdiagnostic models that better reflect the complexity of underlying neurobiological and behavioural systems. The contrast between the DSM-5 and ICD-11 reveals a deeper conceptual

tension: is ADHD a fixed neurobiological disorder, or a contextually dependent cognitive variation? This question highlights the importance of understanding how classification systems do more than describe; they shape the realities they claim to reflect.

2.4 ADHD as a Biopolitical and Symbolic Construction

ADHD classification is deeply embedded in broader sociopolitical and cultural structures. Using Foucault's (1980) analysis of power/knowledge, psychiatric diagnoses can be understood as instruments of regulation that define and manage social norms. "Power produces knowledge... power and knowledge directly imply one another" (Foucault, 1980, p. 27), illustrating how classifications such as ADHD reflect not only scientific criteria but institutional interests in governing deviance. Psychiatry, therefore, functions as a disciplinary apparatus that "extends and delimits" (Rose, 2019, p. 7) the very boundaries of normality, shaping subjectivity by deciding who is, or is not, a suitable case for treatment (Rose, 2019, pp. 6–7). Institutions like medicine, education, and psychology determine which attentional styles are normalised and which are pathologised (Singh, 2011). The evolution of ADHD, from early theories of minimal brain dysfunction to contemporary neurodevelopmental frameworks, demonstrates how these classifications shift in response to sociocultural anxieties about control, productivity, and difference (Barkley, 2015, pp. 7–38).

Conrad and Bergey (2014) argue that the globalisation of ADHD diagnosis is closely tied to economic systems that reward efficiency, attentional control, and self-discipline. Psychiatry, in this context, not only identifies dysfunction but also reinforces normative ideals of behaviour aligned with workplace and classroom demands. Lacan's (2002) theory of the Symbolic order offers a clinically generative lens for understanding how psychiatric diagnoses assign cultural

meaning to experience. From this viewpoint, diagnoses like ADHD shape identity by positioning individuals within a predefined system of language and norms (pp. 248–250). The concept of *passage à l'acte*, a sudden discharge of tension when inner conflict cannot be symbolically articulated, offers a psychoanalytic reading of impulsivity (Lacan, 2002, p. 214).

The biopolitical dimensions of ADHD become particularly visible in adulthood, where the diagnosis is often framed as necessary for sustaining productivity in professional and economic life (Conrad & Bergey, 2014; Druedahl & Sporrang, 2020). In this framing, diagnosis does not merely identify distress, but also reproduces the cultural imperative to self-regulate according to dominant norms.

Although medicalisation has increased recognition and access to support, it has simultaneously entrenched deficit-based models that emphasise individual symptom management rather than structural transformation (Singh, 2011). Pharmacological intervention is frequently promoted as a personalised solution, diverting attention from the institutional contexts, such as schools and workplaces, that uphold neuronormative expectations around attention and conduct (Walker, 2021).

These dynamics exemplify the individualising logic of biopower, wherein responsibility for adaptation is shifted away from systems and onto the diagnosed subject. By framing ADHD through Foucauldian and Lacanian lenses, this section highlights how psychiatric discourse operates not only as a clinical tool but as a mechanism for managing conformity, identity, and institutional control. These critiques set the stage for further examining how societal demands around productivity, discipline, and attention shape the experience and interpretation of ADHD.

2.5 Attention and Productivity: Culture, Capitalism, and Conformity

While often framed as a neurobiological condition, ADHD is also a diagnostic category shaped by historical, economic, and cultural forces. As scholars such as Conrad and Bergey (2014) and Singh (2011) argue, contemporary models of attention and performance are informed by capitalist ideals that prioritise efficiency, productivity, and self-regulation. These expectations, embedded in educational and workplace norms, influence which cognitive traits are deemed functional or dysfunctional. As Druedahl and Sporrang (2020) argue in their Foucauldian analysis, “using ADHD medicine or coping techniques can be a means to control one’s body, health and social self” (p. 1205), reflecting how individuals adapt themselves to meet societal demands for performance and productivity.

McCoy’s (2023) discourse analysis of Lacanian-informed clinicians sheds light on how childhood hyperactivity and impulsivity are interpreted not as neurological deficits but as responses to symbolic and institutional pressures. One analyst remarks, “We offer all kinds of enjoyment to children but... we imprison them” (p. 81), pointing to the paradox of overstimulating environments that simultaneously impose rigid behavioural demands. These insights expand Lacan’s theory of the Symbolic by situating ADHD-like behaviours in a cultural context where expression, movement, and desire are tightly regulated. Such behaviours may not indicate internal dysfunction, but instead arise from a clash between the subject’s psychic structure and the demands of an environment that offers stimulation without space for meaning-making or embodied release. In this view, impulsivity and hyperactivity become expressions of affective excess, shaped by broader cultural contradictions about movement, pleasure, and control (Lacan, 2002; McCoy, 2023).

Lloyd (2025) draws parallels between the historical pathologisation of difference and contemporary attitudes toward neurodivergence. He comments that “if you were gay, you were classed as mentally ill right up until 1994,” and that children from racialised communities in the UK were “still classed as educationally subnormal right up until the early ’70s” (11:15). These examples, he argues, reveal how psychiatric frameworks have historically constructed forms of human variation as deviant, shaped by dominant cultural norms. Until recently, he adds, even the NHS website framed ADHD as associated with criminality and substance misuse, reinforcing a view of neurodivergence rooted in moral failing rather than cognitive difference (21:30). Lloyd (2025) critiques how public health systems have historically reinforced such stigmatising associations, perpetuating a view of ADHD that links it to criminal behaviour and substance misuse (21:35–21:53). “I do not believe it is a disorder,” he reflects, “I think it is a natural expression of the diversity of human neurocognitive capability and potential” (49:00). For Lloyd (2025), ADHD is not a fixed internal deficit but a relational and contextual phenomenon that emerges through interaction with environments structured by stigma, exclusion, and normative expectations. His reflections reinforce how language, culture, and diagnostic discourse shape whether difference is accepted, accommodated, or pathologised.

Adshead and Horne (2021) extend this critique by reflecting on how psychiatric diagnoses often operate within overstretched systems. In these contexts, diagnosis can function as both a support mechanism and a gatekeeping tool, determining not only access to care but also conformity to dominant expectations of self-regulation and productivity. As they note in their discussion of forensic psychotherapy, “Psychological therapy cannot be forced on anyone” (Adshead & Horne, 2021, p. 36), yet access to care is shaped by stigma and stretched resources.

These critiques are further complicated when viewed across cultures. For example, Kitanaka (2012) demonstrates that Japan's longstanding wariness toward psychiatry, linked to its association with confinement and stigma, only shifted in the early 2000s when depression was reframed as a "national disease" (Kitanaka, 2012, p. 2) tied to overwork and economic pressure. This reframing enabled a more culturally acceptable expansion of psychiatric discourse, not by importing Western biomedical narratives wholesale, but through a negotiated language of distress grounded in local social values (Kitanaka, 2012, pp. 1–6).

Japan illustrates how cultural imperatives of *gaman* (perseverance) and *wa* (harmony) can suppress help-seeking and keep ADHD diagnosis rates low, reinforcing the earlier point that local norms mediate recognition and treatment (Kitanaka, 2012; Ando et al., 2013; Kanehara et al., 2015).

Thus, the interplay of cultural attitudes, societal stigma, and the healthcare system creates a challenging environment for recognising and treating ADHD and broader mental health issues in Japan (Kitanaka, 2012; OECD, 2019; Ishikawa et al., 2015). This pattern, observed in various global contexts, underscores the urgent need for culturally sensitive interventions and increased awareness (Ando et al., 2013; Kanehara et al., 2015). Understanding these dynamics informs culturally appropriate care and foreshadows the next section on intersectional inequities.

2.6 Intersectionality and Diagnostic Disparities: ADHD and Social Marginalisation

The diagnosis of ADHD is shaped by intersecting social factors, including race, class, gender, and access to care. An intersectional perspective (Crenshaw, 1989, 1991) highlights how these dimensions overlap to influence who receives a diagnosis, how behaviours are interpreted, and who is supported or excluded within psychiatric and educational systems. This lens reveals

how diagnostic processes can compound marginalisation, particularly when individuals do not conform to dominant behavioural norms or face barriers to accessing care (Conrad & Bergey, 2014). ADHD is not evenly distributed across all populations. Research consistently shows that individuals from racialised groups, low-income households, and criminal justice settings are less likely to receive accurate diagnoses or appropriate treatment. For example, ADHD is prevalent among incarcerated populations, yet a significant number of individuals in these settings go undiagnosed and untreated. A systematic review and meta-analysis found that the prevalence of ADHD in prison settings can be as high as 20.5%, with many inmates experiencing substantial psychiatric comorbidity that remains unrecognised (Vélez-Pastrana et al., 2020; Young et al., 2015). These disparities raise urgent ethical concerns about equity, justice, and access within psychiatric care.

Although awareness of ADHD has grown, access remains heavily shaped by socio-economic status, with wealthier, predominantly white individuals having greater access to diagnostic services and medication (Young et al., 2014; Farooq et al., 2015). Moreover, diagnostic practices are frequently influenced by racial bias, particularly within educational systems. Studies indicate that racialised and lower-income children with ADHD often face punitive measures instead of supportive interventions, exacerbating their challenges (Young et al., 2014; Gudjónsson et al., 2012). In the United States, for instance, Black and Latino boys are disproportionately diagnosed with ADHD and frequently prescribed stimulants as behavioural control mechanisms in schools, more as disciplinary strategies than therapeutic interventions (Young et al., 2015).

The evidence strongly points to the influence of systemic bias in both the identification and treatment of ADHD, emphasising the necessity for reforms in educational and psychiatric practices to mitigate these disparities (Young et al., 2015; Farooq et al., 2015). As a result, the intersection of gender and cultural expectations shapes the experience of ADHD and reinforces structural inequities in how the disorder is understood and treated across diverse populations (Babinski et al., 2011).

2.7 Reframing ADHD Support: Inclusion and Neurodiversity Futures

As the previous section showed, ADHD diagnosis is not equally accessible across all populations, leaving many individuals, especially those from marginalised and gender-diverse groups, without adequate recognition or support. These systemic disparities extend beyond diagnosis and shape access to accommodations in education, employment and therapy, underlining the need to replace deficit-oriented interventions with structural models that centre accessibility and inclusion (Hinshaw et al., 2021; Young et al., 2015).

Neurodiversity-informed scholars recast ADHD traits as natural cognitive variation rather than deficits to be corrected (Walker, 2021). Hallowell and Ratey (2021) describe this as an “abundance” of attention, which may present as hyperfocus, creativity, and lateral thinking (p. 78). Lloyd (2025) expresses a similar view, describing ADHD as “a natural expression of this diversity of mind... integral to humankind” (50:16), and urging a shift from disorder to intelligence (50:46). He also reflects on how stigma and misrecognition foster internalised shame (50:30). While diagnosis can offer access to support and self-understanding, Lloyd (2025) warns it may also function as a gatekeeper, excluding those who do not meet narrowly defined criteria.

Educational redesign offers one practical route forward. Universal Design for Learning proposes “multiple, flexible methods of presentation, expression, and engagement” that anticipate cognitive variability instead of bolting on supports after diagnosis (Rose & Meyer, 2006, p. viii). In practice, this includes movement-friendly classrooms, assistive technologies, multimodal assessments, and digital scaffolds that support students without requiring proof of disability. “The curriculum is broken, not the child,” Rose and Meyer (2006) explain, calling for course design that “accommodates the greatest number of students” from the outset (p. 37).

Parallel changes are emerging in the workplace. Some companies have replaced conventional interviews with strengths-based assessments and informal team “hangouts” to uncover talents often missed by standard HR filters (Austin & Pisano, 2017). As Robison (2013) explains, “Neurodiversity is the idea that neurological differences like autism and ADHD are the result of normal, natural variation in the human genome... people with differences do not need to be cured; they need help and accommodation instead” (para. 3). Hewlett Packard Enterprise’s South-Pacific division reports that its neurodiversity programme “delivers benefits at more levels than any other initiative” (Nick Wilson, quoted in Austin & Pisano, 2017, para. 11). Testing teams in the programme have shown approximately 30% greater productivity, and SAP analysts have developed tools now used by thousands of clients (Austin & Pisano, 2017, paras. 14–15). These outcomes suggest that treating attentional difference as a resource can foster both inclusion and innovation.

Such programmes are still exceptional and often favour applicants who already possess the cultural capital to navigate selective pipelines. For change to become genuinely inclusive,

accessibility must shift from discretionary add-on to default design principle in both corporate and public sectors (Rose & Meyer, 2006; Austin & Pisano, 2017).

Psychoanalytic and therapeutic models add a further dimension. While cognitive-behavioural approaches often focus on executive dysfunction, psychoanalytic frameworks attend to the affective and unconscious roots of attentional and impulsive difficulties (Salomonsson, 2017, p. 12). For example, Lacanian theory interprets impulsivity as passage à l'acte; a discharge of tension when symbolic mediation fails (Lacan, 2002, pp. 214–217). In this view, impulsive acts are not simply executive lapses but emerge from internal conflict and cultural pressure, erupting when meaning collapses and action becomes the only outlet. Integrating these perspectives invites a move beyond rigid diagnostic models toward environments in education, work and therapy that actively embrace neurodiversity and make varied attentional styles both visible and valuable.

2.8 Chapter Discussion: Classification, Marginalisation, and Emerging Frameworks

This chapter has examined ADHD not as a static neurodevelopmental disorder, but as a shifting construct shaped by cultural norms, symbolic systems, and institutional power. Drawing on Foucauldian, Lacanian, and neurodiversity-informed perspectives, it has shown how diagnostic categories like ADHD function not only as tools for support, but also as mechanisms of regulation and exclusion (Foucault, 1980; Lacan, 2002; Walker, 2021). From this lens, ADHD becomes legible as both a site of struggle and a site of meaning-making, where experiences of distress or difference are filtered through systems that determine what is valid, what is treatable, and what is simply misunderstood.

Cross-cultural perspectives, such as the Japanese example, illustrate how behaviours associated with ADHD may be celebrated, overlooked, or pathologised depending on prevailing norms. These insights challenge assumptions of universality in diagnosis and reinforce the value of culturally grounded approaches to care (Kitanaka, 2012; Davis et al., 2012).

Diagnostic disparities remain deeply shaped by race, class, gender, and geography. These findings prompt critical reflection on whose suffering is recognised, whose difference is supported, and how psychiatric legitimacy is granted or withheld (Young et al., 2015; Rucklidge, 2010).

Emerging frameworks, including psychoanalytic and neurodiversity-informed models, offer more relational and context-sensitive understandings of ADHD, shifting the focus from dysfunction to meaning, agency, and accommodation (Salomonsson, 2017; Lloyd, 2025).

Structural innovations such as Universal Design for Learning illustrate how institutions can move from reactive intervention to proactive inclusion, embedding flexibility and accessibility from the start (Rose & Meyer, 2006). Instead of demanding evidence of dysfunction, these frameworks recognise variability as a given.

As we turn to Chapter Three, the focus shifts from how ADHD is classified to how it is narrated. Public discourse, media, and gendered expectations all shape who is seen, who is heard, and who remains invisible. Continuing with a critical, interdisciplinary lens, the next chapter explores how cultural stories, whether empowering or pathologising, influence not only self-perception but therapeutic engagement.

CHAPTER THREE: Stigma and Cultural Constructs

3.1 Neoliberalism, ADHD Coaching, and Therapeutic Ethics

Neoliberalism, characterised by market competition, individual responsibility, and self-optimisation, has significantly reshaped the mental health landscape. Within this framework, distress and cognitive difference are reframed as private burdens to be managed through individual effort, rather than social phenomena rooted in structural inequity (Fisher, 2009; Rose, 2019). The rise of ADHD coaching exemplifies this trend. Instead of addressing systemic exclusions, coaching interventions often place the onus of adaptation on neurodivergent individuals, reinforcing a culture of self-management and behavioural compliance (Moth, 2018).

ADHD coaching has expanded rapidly in the past two decades, mirroring the broader self-improvement economy's emphasis on productivity and executive-function optimisation (Kubik, 2010). Typical programmes promise help with time management, emotional control, planning, and goal-tracking; skills that align closely with neuronormative expectations of the efficient worker or citizen (Kubik, 2010; Ramsay & Rostain, 2007).

Kubik (2010) positions coaching as “an intervention that complements treatment plans ... [and] builds life skills to change negative outcomes and beliefs” (p. 442). She likens it to psycho-education that helps adults “make a logical connection to their current cognitive, emotional, and behavioural responses” (p. 443). Yet she also cautions that “there are no scientific studies demonstrating that coaching of any type is an effective intervention in the treatment of adults with ADHD” (p. 443).

Enthusiasts counter that coaching tackles the “nitty, gritty stuff that medication does not address,” such as getting organised or finding better work (Quinn, 2007, as cited in Kubik, 2010,

p. 443). Ratey (2008) calls it “the difference between minimal functioning and true, full living” (Ratey, 2008, as cited in Kubik, 2010, p. 13). Even Kubik notes that coaches “do not treat comorbid depression or anxiety,” (2010, p. 443; see Ramsay & Rostain, 2007, p. 344) advising referral to therapy or medication when such barriers arise.

From a clinical standpoint, executive-function impairments remain a core and persistent feature of ADHD. Barkley (2015) stresses that the disorder is “linked to substantial and pervasive EF deficits in everyday life” (pp. 65–67), underscoring that these deficits cannot simply be “coached away.”

Taken together, the literature suggests that ADHD coaching can provide a useful day-to-day scaffold, especially for translating clinical insight into concrete routines, while the deeper neurocognitive and systemic dimensions of the condition are better addressed through evidence-based medical and psychotherapeutic interventions (Barkley, 2015; Kubik, 2010; Ramsay & Rostain, 2007).

Access to ADHD coaching is also shaped by economic inequality. As a non-publicly funded intervention, it is frequently restricted to those with the financial means to afford it. This reinforces the commodification of psychological support and positions coaching as a resource of the privileged. In their review of global access to mental health care, Patel et al. (2007) argue that unmet mental health needs are most pronounced among low-income populations, with barriers stemming from workforce shortages, stigma, and inadequate service integration. Similarly, Santiago et al. (2012) found that individuals from socioeconomically disadvantaged backgrounds face significant obstacles in initiating and sustaining psychotherapy, underscoring structural

inequities in mental health care delivery. ADHD coaching, though less stigmatised, remains part of this broader terrain of stratified care.

Fisher's (2009) concept of "capitalist realism" is particularly resonant here. He notes that more effort is often spent "ensuring that a service is represented correctly than into actually improving those services" (p. 45). ADHD coaching can be seen as part of this dynamic, offering the appearance of support without addressing root causes of distress or exclusion. As Fisher (2009) writes, "all that is solid melts into PR" (p. 46), highlighting how performative gestures toward inclusion may obscure enduring structural neglect. Coaching, while helpful to some, can thus function as a symbolic nod to accessibility, masking persistent socioeconomic and cultural inequities. As Cosgrove and Karter (2018) argue, critiques of neoliberal mental-health culture suggest that biomedical 'cures' often reproduce the very market logics they claim to remedy. This complicity with neoliberal performance culture raises ethical questions for psychotherapists working with neurodivergent clients.

Rose (2019) contends that therapy must go beyond individualised coping models and actively engage with the sociopolitical conditions that shape suffering (pp. 20–21). This is particularly salient for ADHD, a condition frequently pathologised within systems designed to reward conformity, speed, and productivity. If therapeutic practice uncritically adopts neoliberal logics of adaptation and self-regulation, it risks replicating the very forces that marginalise neurodivergent individuals. A more critical, contextually informed approach is needed, one that supports individual growth while interrogating the cultural and structural conditions in which neurodivergence is lived (Chapman, 2021, p. 1365).

3.2 Stigma, Criminalisation, and Social Exclusion

As Twomey (2025) stated in her ADHD Connections video, “We have taken an individual's irreversible profile and only highlight the negatives. We repeatedly report to society on the ‘problems’ ADHDers experience and create... Then we wonder why they struggle” (video posted March 3, 2025). This quote captures the tendency in society to frame ADHD through a deficit-based lens, often overlooking context, individual capacity, and strengths. Despite growing recognition of ADHD, adults with the condition continue to face significant stigma, which distorts public understanding and negatively impacts self-perception. As Link and Phelan (2001, as cited in Flanigan, 2021) define, stigma arises through processes of labelling, stereotyping, separation, and discrimination within a power dynamic. For adults diagnosed later in life, these dynamics can contribute to diminished self-worth, delayed access to care, and reluctance to disclose struggles. Kellison et al. (2010, p. 368) further note:

Higher stigma perceptions may signal the need for further assessment of emotional symptoms, including depression and self-esteem. If depression and low self-esteem are rooted in a perceived legitimacy of public attitudes, this might signal the need for different treatment strategies for the mood symptoms.

Furthermore, stigma is not confined to the diagnosed individual; caregivers also report ‘affiliate stigma’, internalising public blame (Chang et al., 2020).

There is a persistent misconception that ADHD is a modern invention or a diagnosis of convenience, often equated with laziness, low intelligence, or poor parenting (Ginsberg et al., 2014; Hinshaw et al., 2021). These stereotypes reflect a deeper cultural unease with cognitive

and behavioural difference. Lloyd (2025) links the resulting shame experienced by neurodivergent individuals to inadequate public health messaging, while Walker (2021) contends that the pathologisation of ADHD stems from normative anxieties about deviation and control.

Stigma operates through both individual attitudes and structural mechanisms. Scanlon and Adlam (2013) describe this process as one of misrecognition and reflexive violence, wherein individuals internalise social rejection and are excluded from systems of belonging. ADHD, in this context, becomes a label that restricts rather than supports, reinforcing narratives of incapacity rather than recognising adaptive strategies or unmet needs.

The criminal justice system offers a stark example of such exclusion. Young and Cocallis (2019) note that individuals with ADHD are disproportionately represented in carceral systems due to cumulative disadvantage, including early school exclusion, misinterpreted behaviour, and a lack of accommodations. Impulsivity, emotional dysregulation, and executive dysfunction are often mistaken for aggression or defiance. As a result, neurodivergent individuals are more likely to be punished than supported, and once incarcerated, they often remain undiagnosed and untreated, contributing to higher recidivism rates and reinforcing harmful associations between ADHD and criminality.

Public narratives surrounding ADHD reflect the regulatory power of discourse. Drawing on Foucault (1980), power can be understood not as issuing from a single centre but as embedded in “micro-relations,” gaining access to the “slightest, most individual forms of behaviour” (p. 199) through dispersed strategies of governance. Within this framework, diagnostic categories such as ADHD are not neutral descriptors but participate in the subtle management of difference across social institutions. Druedahl and Sporrang (2020) suggest that

psychiatric diagnoses like ADHD are embedded in biopolitical processes that determine who is treated, how, and under what terms (p. 1204).

Lloyd (2025) challenges deficit-based narratives by calling for a shift away from frameworks that reduce ADHD to pathology. He critiques the role of public health systems and educational institutions in reinforcing stigma, particularly when attentional difference is medicalised without adequate contextual or relational understanding. His broader argument suggests that when social belonging is defined through narrow behavioural norms, those who diverge are positioned as deficient, deviant, or unworthy of inclusion. Drawing parallels with the historical exclusion of racialised and LGBTQ+ individuals from psychiatric and educational legitimacy, Lloyd (2025) positions ADHD stigma within a longer lineage of cultural marginalisation shaped by normative ideals of personhood and functionality.

Such reflections are not unique to Lloyd (2025). They are echoed in critical literature that challenges the curative impulse embedded in dominant mental health discourse (Walker, 2021; Yergeau, 2018). These authors argue for a redefinition of health and difference that moves beyond conformity to neuronormative standards, and instead fosters environments where neurodivergent individuals can thrive without shame.

Taken together, the impact of stigma, criminalisation, and social exclusion points to the urgent need for nuanced, affirming, and intersectional understandings of ADHD. Rather than relying solely on biomedical models that pathologise individuals, it is essential to consider how institutional structures, cultural myths, and social inequities shape both the diagnosis and the lived experience of ADHD. The next section will build on these insights by exploring how gendered narratives further influence diagnosis and access to support.

3.3 Gendered Constructions and Experiences of ADHD

ADHD diagnosis has historically reflected gender biases, with diagnostic criteria primarily shaped by male-coded external hyperactivity. Rucklidge (2010) notes that boys are overrepresented compared to girls by a ratio of 2:1 to 9:1, depending on the subtype and setting (p. 357). This referral bias continues to result in the underidentification of ADHD in girls, especially younger ones.

Gendered biases in ADHD diagnosis continue to shape clinical understanding, as the emphasis on hyperactivity skews diagnosis in favour of male-coded behaviours. This male-centric model has contributed to the underdiagnosis of women and gender-diverse individuals, whose symptoms often manifest in ways that do not align with dominant diagnostic criteria (Retz-Junginger et al., 2010). As a result, the subtler symptom presentations in females, such as emotional dysregulation and executive dysfunction, are often overlooked (Babinski et al., 2011).

Sociocultural expectations of emotional regulation, organisation, and attentiveness obscure the reality that ADHD often manifests as exhaustion, overwhelm, or chronic self-criticism. For women and gender-diverse individuals, these traits are often internalised or masked, which further delays recognition and support (Barkley, 2006; Mowlem et al., 2019). Masking, a strategy where individuals suppress neurodivergent traits to conform to societal norms, is particularly common among women with ADHD (Hull et al., 2017). This exacerbates stigma, leaving those who diverge from gender norms feeling isolated and misunderstood (Quinn & Madhoo, 2014). The pressure to maintain a socially acceptable façade can cause emotional

fatigue and heightened mental health risks, such as anxiety and depression (Raymaker et al., 2020).

The ‘male model’ of ADHD, prioritising impulsivity, external disruption, and hyperactivity, has shaped both clinical understanding and individual self-perception, often overlooking traits more common in women, such as inattentiveness and emotional dysregulation (Rucklidge, 2010). McCabe (2024) reflects on this, describing how gendered expectations led her to believe ADHD did not apply to her, as she did not fit the stereotype of a boy “bouncing off the walls” (p. 21); instead, she describes her younger self as daydreamy and overwhelmed, struggling silently with the internal chaos of her mind. Similarly, Khorsandi (2023) describes how she internalised her struggles with ADHD, recalling that “as much as I possibly could, I held all that energy inside me, the chatter building up until I became like a little pressure cooker and I did something I shouldn’t, just for a split second of tension relief” (p. 51). She reflects that “I learned to mask every uncomfortable feeling” (p. 53) and lived in “terror that people would find out” (p. 55) when she acted impulsively. Her account illustrates the emotional fatigue and shame caused by undiagnosed ADHD, driven by hypersensitivity, internalised pressure, and an inability to self-regulate.

This diagnostic disparity extends across cultures. In Japan, cultural norms place a high emphasis on emotional restraint and adaptability. Hayashi et al. (2019) found that Japanese women with ADHD face unique pressures to conform to traditional feminine ideals, such as modesty and emotional control, which may obscure symptoms and delay diagnosis. The intersection of gender and culture further reinforces the social construction of ADHD, illustrating

how these frameworks are imbued with cultural assumptions that challenge the notion of clinical neutrality.

Beyond diagnostic biases, many women and gender-diverse individuals develop compensatory strategies such as masking to navigate social and professional environments. Masking refers to the suppression of neurodivergent traits and the imitation of socially normative behaviours to avoid stigma or social exclusion (Hull et al., 2017, p. 2520). This aligns with Goffman's (1963) broader theory of stigma, in which individuals manage their identities to conform to dominant social expectations. While masking can enable temporary success, it is often associated with emotional suppression, chronic exhaustion, and higher rates of anxiety and depression. Raymaker et al. (2020) describe this phenomenon as a key factor in 'autistic burnout' (p. 134), characterised by pervasive fatigue, loss of function, and reduced tolerance to stimuli. For women, in particular, societal pressures to appear competent, emotionally regulated, and self-sufficient may intensify these effects, creating a tension between outward presentation and internal experience.

Hormonal changes during puberty can complicate ADHD symptom management, particularly for girls navigating increasing academic and social demands (Young et al., 2020, pp. 7–8). These challenges are often compounded by gendered clinical biases, where executive dysfunction and emotional dysregulation are misattributed to mood disorders, contributing to delayed diagnosis and treatment (Young et al., 2020, p. 9). Additionally, early pregnancy and risky sexual behaviour have been noted as more common among adolescent girls with ADHD, reflecting both impulsivity and vulnerability in this population (Quinn & Madhoo, 2014).

Lacanian psychoanalysis provides a compelling lens for understanding gendered diagnostic disparities in ADHD. Lacan (2002) argues that subjectivity emerges not from inner essence but from the subject's relation to language and the symbolic structures that pre-exist them. As he writes, 'the subject constitutes himself on the basis of the message, such that he receives from the Other even the message he himself sends' (p. 293). From this perspective, culturally idealised gender roles act as symbolic anchors that shape what forms of expression are seen as intelligible. When traits such as emotional intensity, disorganisation, or impulsivity do not align with dominant norms of femininity or masculine control, they may be rendered culturally invisible or pathologised. Lacan notes that desire begins “in the margin in which demand rips away from need” (p. 299), leaving the subject suspended in a space where certain expressions may feel unspeakable. For women and gender-diverse individuals, this can result in internalised shame, delayed recognition of ADHD, and limited access to appropriate support. What is not symbolised remains unrecognised, and thus the subject may become split between their lived experience and what culture permits them to articulate.

The consequences of ADHD underdiagnosis in women extend beyond individual struggles, shaping access to care, career development, and identity formation. For many late-diagnosed women, the diagnosis is both a relief and a source of retrospective grief. As Middleton reflects, “through my teenage years I was always misdiagnosed or diagnosed with generalised anxiety disorder, panic disorder and anxiety-related depression” (Middleton. 2024, 3:15). This pattern of misrecognition, common across the neurodivergent community, often leads to lost opportunities and an internalised sense of failure. Reflecting on the emotional cost of late diagnosis, Middleton notes, “I just wish that I could have one day where everything would run smoothly... the simplest things take up so much effort and so much brain space” (Middleton et

al., 2024, 55:02–55:10). She describes the psychological toll of performing functionality, stating, “I just turned myself into the version of myself that I thought the people around me wanted me to be” (Middleton, 2024, 0:32–0:37). Speaking candidly in a later roundtable, she reframes this survival strategy as “a new form of masking,” acknowledging, “I am not masking as a neurotypical person anymore, but I am masking as the ADHD expert” (Middleton et al., 2024, 6:24–6:38).

This theme of duality resonates throughout the roundtable. Brown describes the dissonance between perceived competence and internal struggle: “It’s not just how my brain works, but how it fits into life... everything has just been more difficult than I thought it would be” (Middleton et al., 2024, 4:12–5:31). Duguid expands on the cost of public vulnerability, explaining how she often shared her experiences only after she had “crawled up maybe three ladder steps of the ten-step ladder” (Middleton et al., 2024, 9:01). The pressure to remain visible and relatable while privately struggling became “self-perpetuating” (Middleton et al., 2024, 9:14), leading her to temporarily retreat from public view. Middleton captures the affective weight of such contradictions, describing “a grief looking forwards” as she reflects on the realisation of how persistent these challenges may be (Middleton, 2024, 1:15:03). These reflections expose the psychological cost of social camouflage and the entanglement of ADHD, gender, and survival. Together, the women articulate a shared longing for spaces where unmasking can occur safely, spaces that psychotherapy may be uniquely positioned to provide.

3.4 The Medicalisation of ADHD: Power, Control and Diagnosis

Building on the diagnostic frameworks outlined in Chapter Two, this section examines how medicalisation influences adult experiences of ADHD, connecting personal

meaning-making with societal expectations around control and productivity. Framing ADHD as a disorder that requires intervention reflects broader societal anxieties regarding attention, discipline, and performance. Mainstream psychiatric discourse continues to focus on neurochemical imbalances and executive dysfunctions, reinforcing a biomedical narrative that emphasises symptom reduction and behavioural conformity (Timimi & Taylor, 2004, pp. 8–9).

While diagnostic systems differ in structure, both the DSM and ICD remain grounded in medical paradigms that prioritise observable behaviour and individualised treatment. This approach can obscure relational and contextual factors, particularly in adults, where emotional dysregulation, shame, and situational overwhelm often take precedence over childhood hyperactivity (Sonuga-Barke et al., 2016).

From a Foucauldian perspective, psychiatric classification serves not only as a clinical tool but also as a mechanism of social regulation. Foucault (1977) contends that diagnostic categories have disciplinary functions, encouraging internalised self-monitoring in alignment with social norms. Druedahl and Sporrang (2020, pp. 1204–1207) build on this analysis in their examination of ADHD and stimulant use, noting that medication is often framed as a means of regaining control and self-management in line with neoliberal ideals of personal responsibility. In this context, treatment becomes a tool for aligning individuals with dominant productivity expectations rather than addressing the broader systems contributing to their distress.

The emotional implications of diagnosis are significant. While many individuals feel relief from receiving a label that validates their struggles, others express ambivalence when the diagnosis places the source of dysfunction entirely within the self (Moncrieff, 2008). Pharmacological treatments like methylphenidate are often hailed as life-enhancing by

proponents, helping individuals manage daily tasks (Hallowell & Ratey, 2021). However, critics contend that these treatments may unintentionally reinforce deficit-based thinking by positioning attentional difference as something needing correction (Moncrieff, 2008; Timimi & Taylor, 2004).

Critical theorists highlight how late capitalist cultures amplify the medicalisation of attention. Crary (2013) argues that in a 24/7 society, continuous availability, productivity, and alertness are prioritised over rest and reflection, creating a culture where deviations from these norms are pathologised. Fisher (2009) similarly contends that capitalism privatises stress and anxiety, framing systemic demands as individual failings. Within this framework, neurodivergent traits such as impulsivity or difficulty focusing are not merely clinical concerns but disruptions to economic efficiency. ADHD becomes recognised as a disorder largely because it challenges the imperatives of late capitalist productivity.

The medicalisation of ADHD reflects a biopolitical logic, where diagnosis serves both therapeutic and normative functions. As Foucauldian scholars have shown, diagnostic categories do more than identify problems; they shape how individuals understand themselves and how they are viewed within social systems (Foucault, 1977; Druedahl & Sporrang, 2020). This regulatory role often centres on personal responsibility, reinforcing the idea that success or failure depends on one's ability to self-manage, while obscuring the social and institutional conditions that limit individual agency (Moncrieff, 2008; Walker, 2021).

These discursive and structural dynamics set the stage for the next section, which explores how public discourse and media representation contribute to the amplification of stigma

and misrecognition, particularly among adults navigating the complexities of late-diagnosed ADHD.

3.5 ADHD in the Media: Stereotypes, Resistance, and Stigma

Media narratives have significantly shaped public attitudes toward ADHD, often reinforcing stigma and diagnostic scepticism. In news reporting and entertainment media, ADHD is often reduced to a childhood disorder characterised by hyperactivity, inattentiveness, and disruptive behaviour (Mueller et al., 2012; Godfrey et al., 2021). Such depictions rarely acknowledge its persistence into adulthood or the more internalised features of executive dysfunction, shame, and emotion regulation that affect many adults (Hinshaw & Ellison, 2015, pp. 6–9), with Hinshaw and Ellison observing that “life without hardy executive functions can be chaotic” (p. 7).

Recent empirical evidence indicates that public perceptions remain grounded in these outdated stereotypes. Godfrey et al. (2021) found that participants in a simulation study significantly overestimated impairments in hyperactivity, impulsivity, and risk-taking, while underestimating challenges related to self-concept and internalised experiences. These findings suggest that societal conceptions of ADHD remain based on externalised childhood behaviours, despite broader clinical understandings of its adult manifestations. Notably, Godfrey et al. (2021) also found that increased ADHD knowledge did not correlate with more accurate perceptions, raising questions about the efficacy of traditional public education campaigns. While Lloyd (2025) advocates for stronger institutional messaging to counter misinformation, these findings suggest that informational campaigns alone may not be enough. Instead, narrative-based and

relational approaches, centred in lived experience, may be more effective in shifting public understanding.

Television and film have traditionally emphasised the most visible traits of childhood ADHD, often omitting or caricaturing adult presentations. Recent investigations have turned to digital platforms. Yeung et al. (2022) found that approximately half of the most-viewed ADHD-related TikTok videos were classified as misleading, often promoting simplified or inaccurate symptom portrayals. Although these platforms offer space for personal narrative and community, the dominance of non-clinical creators contributes to the ongoing circulation of reductive or erroneous content. This may reinforce misconceptions, particularly among younger viewers, highlighting the need for critical engagement with digital representations (Yeung et al., 2022). While public discourse has slowly become more receptive to neurodiversity, such shifts remain uneven. Content creators frequently reframe traits like impulsivity and divergent thinking as signs of creativity or as part of a reframed identity, offering a counter-narrative to deficit-based framings. Although McCabe (2024, pp. 16–18) does not use the term “superpower,” she notes that “for those with access to all the supports they need, ADHD can feel like a superpower” (p. 17). She also recognises the value of colloquial and identity-affirming language like “neuro-spicy,” particularly “when speaking about my anxiety or trauma” (p. 16), and calls for greater acceptance of diverse linguistic expressions that validate lived experience. Still, idealised portrayals can inadvertently minimise the daily challenges of ADHD, particularly in relation to executive dysfunction, emotion regulation, and social stigma (Mueller et al., 2012).

The rise of neurodiversity advocacy online has become a powerful response to dominant cultural narratives. However, this visibility is not without its backlash. As noted in Nicholson’s

(2025) Guardian review of Chris Packham’s BBC documentary *Inside Our ADHD Minds*, public discourse is becoming increasingly polarised. While some voices dismiss neurodiversity as a TikTok trend or part of an “overdiagnosis culture,” the review positions the programme as a quiet yet powerful rebuttal. Through the stories of Jo and Henry, who share experiences of shame, diagnostic delays, and systemic misrecognition, the documentary challenges scepticism by centring emotional reality and individual complexity (Nicholson, 2025).

Stigma also manifests on an internal level. As McCabe (2024) reflects, ADHD can produce a persistent sense of “failing to be the person I was supposed to be” (p. 1). Her narrative traces the cumulative toll of unmet expectations, shame, and internalised ableism, offering a personal counterpoint to cultural myths of laziness or disorganisation. In her discussion of language, McCabe advocates for an accessible, person-centred lexicon that affirms individual choice, noting that reclaiming terms like “disability” can support both legal protections and psychological self-acceptance (pp. xv–xvi).

Finally, media portrayals intersect with broader issues of structural gatekeeping. Godfrey et al. (2021) underscore the persistence of stigma even in the presence of ADHD knowledge, while Mueller et al. (2012) and Quinn and Madhoo (2014) highlight the diagnostic disparities faced by women, racial minorities, and those from lower socioeconomic backgrounds. As Lloyd (2025) notes, the lack of accessible, trusted information in public systems leaves many turning to digital spaces where both advocacy and misinformation coexist. He acknowledges that “not everything...is nonsense,” but urges institutions to engage more actively in these contested spaces (Lloyd, 2025, 24:36).

In summary, the portrayal of ADHD in the media remains a contested terrain. While digital platforms have created space for community and reframing, they coexist with traditional narratives that continue to centre childhood hyperactivity and question ADHD's legitimacy. A more inclusive media landscape, grounded in lived experience, cultural critique, and relational ethics, may offer one pathway to reduce stigma and create meaningful change.

3.6 Chapter Discussion: Clinical Implications for Psychotherapy Practice

This chapter has explored how stigma, gendered narratives, and cultural representations shape the lived experience of adults with ADHD, often framing attentional differences as deviations from normative cognition despite their grounding in neurodiverse expression (Walker, 2021; Yergeau, 2018). Diagnostic frameworks have historically marginalised women and gender-diverse individuals, whose presentations often diverge from male-normed criteria (Hinshaw et al., 2021; Mowlem et al., 2019). Misconceptions about adult ADHD, compounded by systemic gatekeeping and media caricatures, contribute to delayed recognition, internalised shame, and unequal access to care (McCabe, 2024; Young et al., 2020). These dynamics significantly impact psychotherapy, where clients often carry narratives of misrecognition, chronic masking, and diagnostic ambivalence.

Foucauldian theory provides a lens to understand how ADHD is governed through disciplinary mechanisms that align behaviour with neoliberal ideals of autonomy, efficiency, and control. Psychiatric classification, within this framework, functions as a biopolitical tool, shaping subjectivity through internalised norms (Foucault, 1980; Druedahl & Sporrang, 2020). Interventions such as ADHD coaching, pharmacological treatment, and behavioural strategies, while often well-intentioned, may reflect this regulatory logic by positioning neurodivergent

individuals as responsible for adapting to environments that remain fundamentally unaccommodating. As one Lacanian-informed clinician observed, “here the treatment precedes the disease, which is an aberration in medicine... you have a treatment, you need a patient to fit with the treatment” (McCoy, 2023, p. 87). In doing so, therapy risks becoming a site of adjustment at the expense of critical reflection and transformation.

Lacanian psychoanalysis offers one such approach, emphasising the structuring role of language and the Symbolic order in shaping what can be spoken, recognised, and integrated (Lacan, 2002, pp. 243–248). Within this framework, desire often resists direct articulation and instead emerges through metaphor and metonymy, structures that mark the unconscious and reveal what remains unsymbolised. Such unsymbolised aspects of experience may manifest as psychic rupture, affective excess, or behavioural enactment, particularly when they conflict with normative expectations surrounding gender, emotion, or self-regulation.

At the same time, the rise of neurodiversity-affirming spaces, especially in digital, literary, and peer-led contexts, signals a shift toward more emancipatory frameworks. These narratives challenge the curative impulse embedded in dominant discourse, placing lived experience, identity, and relational complexity at the centre (Walker, 2021). First-person accounts by authors such as McCabe (2024) and Khorsandi (2023) offer nuanced insights into the emotional labour of masking, the grief of late diagnosis, and the ambivalence that often surrounds clinical labels. Such narratives resist reductive framings and position ADHD as a dynamic interplay of traits, relationships, and socio-emotional needs.

For psychotherapists, these insights have significant clinical and ethical implications. A stance grounded in cultural humility, curiosity, and tolerance for uncertainty may be more

effective in supporting neurodivergent clients. Instead of framing diagnosis as objective truth, it is more fruitful to explore how it is experienced, negotiated, and resisted within symbolic, linguistic, and relational frameworks.

Therapists can support clients by holding space for the full complexity of their experience, including shame, resistance, contradiction, and pride, without reducing them to binaries of dysfunction and adaptation. This requires a clinical attitude that sees ambivalence as a generative site of meaning-making, not a problem to be resolved (Finlay, 2002, p. 532; Tracy, 2010, p. 841). Such an approach invites therapists to examine their own assumptions about effort, function, and legitimacy and to situate therapy within broader social discourses of power and exclusion. ADHD, in this view, is not just a neurodevelopmental condition but a socially embedded experience of otherness, often invisibly lived and insufficiently recognised.

Clinically, this demands flexibility, attunement, and a pluralistic approach that considers identity, culture, gender, and narrative context as central to engagement (Rose, 2019, pp. 20–21; McCoy, 2023, p. 87). While psychotherapy cannot alone redress the structural inequities shaping ADHD diagnosis and support, it provides a relational counterpoint, a space where neurodivergent ways of relating, feeling, and knowing are welcomed.

As McCabe (2024) reflects, her intention was not to provide definitive solutions but to create "a toolbox full of strategies tailored to the specific challenges we face in achieving what we set out to achieve" (p. xvi). Therapy has the potential to affirm difference while acknowledging difficulty and supporting resilience in the face of structural constraint.

In summary, stigma is a central force shaping how ADHD is lived, perceived, and pathologised. A responsive psychotherapeutic approach, engaging with symbolic, social, and

emotional dimensions, can create new possibilities for meaning-making, connection, and change. The next chapter builds on this foundation by exploring emotional regulation, a frequently under-theorised component of ADHD, and considers how psychotherapists might more fully engage with the affective texture of ADHD experience within a relational and socially conscious frame.

CHAPTER FOUR: Psychotherapy and the Therapeutic Relationship in Adult ADHD

4.1 Framing Emotional Dysregulation and Executive Challenges

Recent years have witnessed a growing body of evidence positioning emotional dysregulation as a central, though historically under-recognised, component of adult ADHD (Faraone et al., 2019). Traditionally defined by its core triad of inattention, hyperactivity and impulsivity, ADHD has long been treated through models rooted in executive dysfunction and behavioural control. However, this framing has increasingly been critiqued as reductive, particularly in the context of adult presentations, where emotional lability, rejection sensitivity and affective volatility often overshadow the more overt symptoms associated with childhood hyperactivity (Barkley, 2015; Barkley et al., 2007; Retz et al., 2012). As Rosier (2025) reflects, “emotional regulation is the name of the game” (1:09:25) when it comes to adult ADHD, emphasising its central role in everyday functioning.

Several studies have shown that while hyperactivity may diminish with age, difficulties with emotional regulation, including irritability, mood shifts and low frustration tolerance, tend to persist and may even intensify in adulthood. These challenges contribute to significant impairments in occupational, relational and psychological functioning (Hirsch et al., 2018; Shaw et al., 2014). This shift has prompted calls to reconceptualise ADHD not simply as a disorder of attention, but as a broader self-regulatory condition (Barkley, 2015; Faraone et al., 2019). Rosier (2025) articulates this clearly, explaining that “we do not have reliable access to our prefrontal cortex... so we use our emotional centres to make sense of the world” (3:09). Such reliance on emotional cues often leads to misinterpretations and reactivity that can appear disproportionate to the situation.

Emotional dysregulation is increasingly proposed as a fourth core symptom of ADHD (Soler-Gutiérrez et al., 2023), with researchers advocating for its inclusion alongside the classic triad. In a systematic review, Soler-Gutiérrez et al. (2023) found that adults with ADHD consistently scored lower on emotion regulation and were more likely to rely on maladaptive strategies such as suppression and rumination. These difficulties were linked not only to functional impairment and mental health comorbidities, but also to increased risk of criminal conviction. Such outcomes cannot be fully explained by executive dysfunction alone, reinforcing the need for more integrative models.

Hirsch et al. (2018) conducted a confirmatory factor analysis involving 213 newly diagnosed adults with ADHD and proposed a seven-factor model encompassing emotional dysregulation, self-concept difficulties, and the traditional ADHD symptom domains. Their findings supported the view that emotional dysregulation is not merely a comorbid issue, but intrinsic to the disorder itself. They also found that emotional dysregulation was most strongly associated with impaired self-concept, suggesting a bidirectional relationship between affect regulation and identity formation. Rosier (2025) echoes this in her clinical reflections, explaining that:

a lot of us with ADHD have a self-worth that isn't fully formed... we don't develop our sense of self as strongly, we may have strong personalities, but our sense of self, meaning here's where I begin and you end, a lot of my ADHD clients don't have that (5:10–5:35).

She later observes that “the sense of self gets a little wobbly,” (Rosier, 2025, 21:13–21:20), especially when clients internalise others' emotional responses instead of holding

onto their own perspective. Such fragmentation is frequently shaped by years of invalidation, masking, and internalised shame, all of which contribute to ongoing emotional distress (Rosier, 2025).

Several theoretical models support a broader understanding of emotion regulation within ADHD. Barkley (2015) expanded his executive function model to include emotional self-regulation as one of five core domains, alongside working memory, self-directed speech, reconstitution, and behavioural inhibition. Similarly, Wender's Utah criteria identified emotional lability as a defining feature of adult ADHD (Wender, 1998). Together, these perspectives reflect growing consensus that emotion regulation difficulties are central, not peripheral, to ADHD (Faraone et al., 2019; Retz et al., 2012). Rosier (2025) illustrates this vividly through metaphor, stating, "my ADHD is, it's sand, it's everywhere... I'll feel the grit beneath my feet... it affects every nook and cranny of our lives... you can't just go to the beach. No, the beach comes home with you" (1:03:53–1:04:30). The metaphor captures the pervasive nature of ADHD symptoms, particularly affective ones, infiltrating daily life in subtle but significant ways.

From a therapeutic perspective, ADHD's overlap of emotional and executive challenges presents both complexities and opportunities. On one hand, emotional dysregulation can complicate engagement with structured interventions like cognitive behavioural therapy (CBT) or skills-based coaching, which often require sustained attention, working memory, and behavioural planning (Philipsen, 2012; William et al., 2024). Many adults with ADHD report that generic CBT frameworks feel rigid and overwhelming, with some participants describing them as "too short" and "not adapting enough" to ADHD-related needs (William et al., 2024, p. 1).

On the other hand, these emotional and executive complexities also create openings for relationally focused therapies that centre on affective experience, recognising how emotion shapes meaning, identity, and self-understanding (Bateman & Fonagy, 2016). As Bateman and Fonagy (2016) note, affect regulation, attention, and self-control are profoundly influenced by early relational experiences, highlighting emotion as a key therapeutic entry point. Rosier (2025) reflects this in her clinical approach:

There's times you have to stand up to yourself and not believe the narrative that you've written... I have the script going 'they're hating me, they're hating me, I'm pretty sure.' Take a deep breath, stand up to yourself and say, 'Listen, you belong here, say what you need to say, be true to yourself, say it in a kind way, but be true.' So... having that moment of awareness that you are not broken, you're just different.

(47:00–47:32).

This internal reframing is often necessary when clients struggle with self-criticism and rejection sensitivity rooted in developmental experiences of difference and failure.

Psychotherapy that addresses emotion not simply as a symptom to be managed but as a meaningful and valid aspect of the client's lived experience may offer a more holistic and affirming path forward (Bateman & Fonagy, 2016; Chapman, 2021). Instead of viewing executive and emotional challenges as discrete categories, an integrated approach can help individuals understand how their affective world is intimately linked to memory, relational engagement, and self-perception. As Bateman and Fonagy (2010) write, the goal is not simply to

interpret but to “sit side-by-side with the patient, not opposite... focusing attention on another mind” (p. 13), thus restoring a sense of agency and mentalizing capacity.

As the following sections will explore, such deeper therapeutic engagement not only supports symptom reduction but also fosters the development of coherence, relational attunement, and self-compassion.

4.2 Internalised Shame, Masking, and Rejection Sensitivity

For many adults with ADHD, internalised shame is not an incidental experience but a defining feature of the self. The emotional weight carried by late-diagnosed individuals frequently stems from years of misrecognition, repeated failures to meet neurotypical expectations, and chronic invalidation. These accumulations of unmet attunement can have traumatising effects over time (Kellison et al., 2010; Hinshaw et al., 2021). As Maté (2022) describes, trauma fosters a “shame-based view of the self” where one feels “fundamentally deficient” (p. 26). He further characterises ADHD as a “perpetual-motion machine,” (Maté, 1999, p. 30) driven not by volition but by affective dysregulation and attachment ruptures. This emotional instability often leaves individuals oscillating between self-doubt and overcompensation, an affective pattern linked to poor self-concept and increased psychological distress (Kellison et al., 2010).

Middleton (2024) reflects on how this dynamic manifested as a cycle of overperformance and collapse: “I always have like 6 months of ADHD being at the forefront and doing everything... and then I would have a crash and burn” (3:29–3:47). Her description exemplifies how masking can serve as a survival strategy, while burnout and shame become its cost. She later notes that after diagnosis she often “felt like I was playing the role of the neurodivergent person,”

reflecting how complex and performative identity reconstruction can become post-diagnosis (Middleton 2024, 11:24–11:36). Roxanne Pink (2024) recounts that she believed she was “just a bad person” (p. 87) before diagnosis, internalising every lost item, emotional outburst, or broken routine as a moral failing (Pink & Pink, 2024, pp. 87–106). This aligns with Kellison et al.’s (2010) framework, which identifies negative self-image, disclosure concerns, and public attitudes as core components of ADHD-related self-stigma. When disclosure evokes fear rather than relief, the therapeutic task becomes not only recognising the diagnosis but actively unlearning a narrative of defectiveness.

The metaphor of a courtroom recurs in late-diagnosed narratives, where internalised shame assumes the role of both judge and jury. Roxanne Pink describes the “useless monster” as a voice that reads out a litany of executive failings and renders the self irredeemable (Pink & Pink, 2024, pp. 127–148). In psychotherapy, these rigid internal critics may be so embedded that validation alone proves insufficient. Instead, the therapeutic alliance must consistently offer relational safety, co-regulating the shame that emerges in moments of vulnerability and misattunement. These clinical dynamics resonate with Gilbert’s (2009, p. 199) account of Compassion Focused Therapy, which proposes that people burdened by shame and self-criticism often experience caregiving emotions as threatening and therefore benefit from gradually developing a new relational template that allows them to receive compassion safely.

Gendered patterns of masking further complicate these dynamics. Visser et al. (2024) found that young women are especially likely to conceal their difficulties, report feelings of loneliness, and delay help-seeking, while young men are more inclined to withhold disclosure. These findings echo Pink’s account of having her own struggles dismissed as laziness or

irresponsibility, an invalidation that can be intensified for women of colour (Pink & Pink, 2024, pp. 87–106). As she writes, “People of color, or POC, are still massively underdiagnosed in comparison to white people. They are more likely to be labelled as ‘disruptive’ and never offered the diagnosis and treatment that could help them, due to racial disparity” (Pink & Pink, 2024, p. 98). The structural invisibility she describes mirrors a wider concern in the literature; relational survival strategies may become entrenched when clients are misdiagnosed or pathologised. One participant in Visser et al. 's (2024) study recalled that their ADHD was “never recognised” (p. 8) despite clear symptoms, and years of misunderstanding fostered a sense of internal failure and loneliness.

Masking, then, is not merely the suppression of symptoms but a form of social camouflage forged through repeated experiences of ridicule and rejection; many adults with ADHD adopt performative identities: the class clown, the perfectionist, the chronic helper, to avert anticipated shame (Quinn & Madhoo, 2014; Visser et al., 2024; Hull et al., 2017). This aligns with Quinn and Madhoo’s (2014) review, which highlights how gendered expectations contribute to camouflaging behaviours, particularly among women. Roxanne Pink’s reflections on people-pleasing illustrate this dynamic: “I decided that being a super-nice person would keep me safe. That I’d be accepted, liked and conflict-free. So I made myself as small as possible” (Pink & Pink, 2024, p. 107). These adaptations can be protective but often come at the cost of authenticity and relational closeness.

The experience of rejection sensitivity, or RSD, compounds these tensions. Often described as an intense emotional response to perceived criticism or exclusion, RSD reflects a hyper-vigilant attachment system primed for rupture (Bedrossian, 2021; Hallowell & Ratey,

2021). Maté (2019), drawing on Neufeld, describes this dynamic as an “attachment alarm,” alerting the nervous system to potential disconnection (p. 139). Personal narratives, both in published memoirs and public podcasts, echo this theme, noting how short texts or neutral expressions can be interpreted as rejection and how individuals may fear that others “secretly hate” them (Pink & Pink, 2024, pp. 123–125).

The neurobiological basis of these distortions is explained in Hallowell’s (2024) reflections on the default mode network (DMN), which he describes as becoming a “demon” (1:08:19) in the ADHD brain. When left unregulated, it floods the mind with abusive self-talk: “you’re stupid, you’re boring... you’re just a worthless piece of poop” (1:08:38). He stresses that “it’s not the truth you’re uncovering... it’s your mind deceiving you” (1:12:02–1:12:09), highlighting the role of focused attention and engagement in disrupting this cycle. Breaking the DMN loop through embodied practices and meaningful action becomes a central clinical intervention (Hallowell 2024, 1:08:24–1:10:09).

What emerges from these accounts is a profound ambivalence about deserving care. Even after formal diagnosis, many individuals continue to doubt their validity. As Roxanne Pink puts it, “You’re not a bad person” (Pink & Pink, 2024, p. 100), a sentiment that often needs to be repeated, held, and internalised within the therapeutic relationship. In clinical terms, validation needs to move beyond cognitive insight and be affectively and relationally integrated. As Hallowell (2024) affirms: “The shame you have been made to feel since you were in the first grade, it’s not you. Society should be ashamed, not you” (20:19–20:26).

From a psychotherapeutic perspective, these dynamics present both challenge and opportunity. The defences shaped by shame, including avoidance, people-pleasing, and

perfectionism, are most effectively approached with curiosity and compassion. Relational attunement helps clients gradually tolerate the process of unmasking, while therapeutic framing supports a shift from a narrative of defectiveness to one of resilience, difference, and dignity (Germer & Neff, 2013, pp. 856–867).

4.3 The Therapeutic Relationship: Holding, Mirroring, and Countertransference

In work with adults navigating ADHD, the therapeutic relationship often becomes a space where deep affective wounds and unmet needs resurface, particularly for those who have experienced repeated misattunement, invalidation, or emotional neglect (Fonagy et al., 2002, pp. 214–216; Schore, 2012, pp. 50–53). This calls for a psychotherapeutic stance grounded in presence, emotional attunement, and reflective capacity. Unlike structured or manualised interventions, relational psychotherapy offers a space in which being held, mirrored, and emotionally understood can itself become reparative (Winnicott, 1965, pp. 43–44).

Yalom (1980) asserts that “it is the relationship that heals” (p. 5). For adults with ADHD, the consistent presence of a therapist who is curious, empathic, and non-shaming can be transformative. These conditions may be especially reparative for those whose early environments failed to support affect regulation or stable attachment. As Conway (2012) notes in relation to children with ADHD, “disturbances in early relational life can lead to the child experiencing difficulty in regulatory capacities including recognizing and managing affective experiences” (p. 410). In therapeutic terms, Buber’s (1970) concept of the I–Thou relationship becomes relevant, describing a mutual, authentic encounter where the client is met as a whole person rather than a problem to be fixed. Clarkson and Pokorny (1994, pp. 38–39) frame this as a

genuine relationship in which healing can emerge through presence, respect, and non-objectification.

The emotional toll of masking is not only social, but also deeply embodied. As Rackley (2024) explains, “They’re holding back, they’re not being their authentic selves... that comes at a very high price in terms of the anxiety” (30:22–30:48). Partridge elaborates on this inner conflict:

That price is... the struggle to find your true sense of self... If you've got these two opposing characteristics and sometimes they're literally pulling you in different directions... how hard is it, if you have that internal tug of war, to find your true self? (Rackley & Partridge, 2024, 30:48 - 31:09).

Rackley (2024) continues:

It’s very tough... because in order to find your true self, then you have to be allowed to be comfortable... to say, this is what I like... the stuff that feeds my soul... If you are constantly tuning out of that, then you are never really living an authentic life... it’s constantly trying to please other people or give other people what you think is going to give you acceptance... There is a huge disconnect in that. (31:10 - 32:04).

This internal dissonance frequently re-emerges in therapy as clients begin to test whether both their masked and unmasked selves can be held in the relationship. These tentative

disclosures may evoke strong countertransference, especially when emotional expression appears erratic, inhibited, or inconsistent. As Rackley (2024) notes: “The RSD, the... sensitivity, the... sense of being overwhelmed” (5:31–5:36).

These reactions, often interpreted behaviourally, may reflect longstanding relational templates shaped by repeated experiences of being misunderstood or dismissed. Clarkson and Pokorny (1994) describe the reparative developmental and transference–countertransference relationships as central to therapeutic work. Transference refers to the re-enactment of early relational dynamics in the therapy space, while countertransference encompasses the therapist’s full emotional response, which can be a valuable source of clinical insight. Attending to one’s own somatic and affective reactions may reveal unconscious emotional landscapes. Forgetfulness, shutdown, or apparent resistance might carry echoes of earlier experiences of misattunement rather than mere in-session behaviour. In this context, the therapist’s own somatic or affective responses may not be obstacles, but doorways into the client’s unspoken emotional landscape (Clarkson & Pokorny, 1994, pp. 31–45).

A central therapeutic task is to mirror affect in ways that help clients name and tolerate previously unintegrated emotional states. O’Kane (2024) captures the emotional complexity often present: “People think anxiety is like a... feeling in itself, but it comes with a whole lot of other feelings... It comes with fear, it comes with dread, it comes with overwhelm” (1:25–1:31).

Holding space for such complexity, without rushing to fix it, aligns with Rogers’ (1980) emphasis on congruence, unconditional positive regard, and empathic understanding (pp. 113–115). For clients who have internalised shame as a core part of their identity, this acceptance in moments of dysregulation may offer a powerful corrective experience. However, rethinking

unconditional positive regard for neurodivergent clients requires therapists to confront the value judgements and implicit biases that can obstruct genuine acceptance (Wilkins, 2010; Cosgrove & Karter, 2018), particularly when therapeutic neutrality risks overlooking broader systems of exclusion.

At the same time, the longing to be understood can coexist with a deep fear of being too much to hold. Rackley (2024) articulates “the real longing in ADHD for connection” (7:35), which is frequently complicated by protective distancing. He explains, “They can get very overwhelmed with certain senses... or certain things that touch their skin... With ADHD, it’s how the person regulates their emotions...” (7:54–8:29).

These dynamics echo attachment-based theories about the fear of emotional engulfment or abandonment. Bowlby (1988) and Wallin (2007) both argue that early disruptions in attachment may lead to intimacy being experienced as unsafe. Within a secure therapeutic relationship, clients may begin to test these expectations and experience themselves differently.

This is reminiscent of Winnicott’s (1965) notion of the “holding environment” (p. 47), which supports movement from fragmentation towards coherence. Duguid, for example, described how her habitual pattern of self-disclosure masked deeper feelings of shame and disconnection. After receiving messages from readers moved by her writing, she reflected, “There I was like, what am I doing hiding away? I was hiding away because I felt like I’d been punished for speaking about things that friends don’t want to see or hear” (Middleton et al., 2024, 10:44–10:55). Being received without judgement facilitated a cautious re-emergence with greater authenticity. This mirrors Fonagy et al. 's (2002) view that affect regulation and mentalization develop through emotionally safe, co-regulated interactions (pp. 214–216).

While structured approaches like CBT are useful for managing executive dysfunction, they may not address the relational and intrapsychic consequences of chronic invalidation and shame. Relational therapy does not seek to normalise emotional difference, but rather to meet it with attunement and faith in the client's capacity for self-integration (William et al., 2024). As Erskine and Moursund (2011) argue, the therapist's engagement with the client's affect script, those internalised relational patterns, offers a powerful avenue for transformation (p. 54). The therapeutic relationship thus becomes both scaffold and mirror, enabling clients to risk connection, deepen their self-understanding, and begin to reimagine identity beyond the limits of deficit-based narratives.

4.4 Affirming Identity and Adapting Practice: Towards Neurodiversity-Affirming Therapy

As this chapter has explored, many adults with ADHD arrive in therapy carrying a deep sense of uncertainty about who they are, shaped by years of invalidation, internalised shame, and the exhausting effort to appear neurotypical in environments that reward conformity. This masking, while once protective, can become self-effacing. Middleton captures this tension: "It feels like unmasking but it's actually just a different type of masking almost... it's a box that's more like me, but it's still a box" (Middleton et al., 2024, 7:10–7:21). Over time, such survival strategies can erode a coherent sense of identity, leaving clients unsure how to exist without a script. Yergeau (2018) names this dispossession: "My very being became a story, a text in dire need of professional analysis... I was no longer my body's author" (p. 1). Diagnosis can therefore bring emotional vertigo, unravelling narratives once relied upon to survive. As Middleton reflects elsewhere, "I feel like I'm living out, like a dual life... the bright shiny person that the world sees... it's almost like a new form of masking" (Middleton et al., 2024, 5:45).

Such moments call for a therapeutic response that attends to distress while affirming neurodivergent experience. As Chapman (2021) argues, the neurodiversity movement seeks to “end what proponents see as the default pathologization of neurodivergence” (p. 1) and replace it with accommodation and acceptance.

These ideas carry clear implications for practice. An affirming stance prioritises both relational and structural flexibility. Adjusting pace, format, or sensory conditions is not a concession but an authentic invitation that communicates welcome. As Kapp (2020) notes, the neurodiversity movement “advocates for the rights of neurodivergent people, applying a framework that values the full spectra of differences and rights such as inclusion and autonomy” (p. 2). This ethos invites therapeutic spaces where identity can unfold without externally imposed definitions, fostering self-authorship and acceptance. Conway (2012) similarly urges clinicians to focus on internal states and relational context rather than symptom correction. Diagnosis seldom delivers neat resolution; instead, it invites re-navigation, prompting clients to revisit their histories through new lenses. In this light, therapy is best guided by exploration over prescription. Fonagy and Target (2002) emphasise that attachment relationships “facilitate the development of the brain’s major self-regulatory mechanisms, which in turn allow the individual to perform effectively in society” (p. 328), underscoring the importance of environments that foster both regulation and narrative reintegration.

The neurodiversity paradigm provides a vital framework for such reorientation. Rather than pathologising difference, it foregrounds the role of context, culture, and relational environments in shaping how traits are interpreted. Kapp (2020) warns that while biological framing can foreground ethical concerns, it may also support the persistence of harmful or

pseudoscientific interventions. He critiques the ongoing promotion of “rejected and unproven theories that offer dangerous ‘treatments’ like heavy metal-injecting chelation therapy, chemical castration (Lupron therapy), bleach enemas, and vaccine avoidance,” noting that some interventions have been “at least ill-conceived” (p. 7). At the same time, he stresses that neurodiversity-informed perspectives recognise the interaction between biological vulnerabilities and social environments, highlighting the need for supports that address both individual needs and structural barriers (Kapp, 2020, p. 7). This view shifts the focus from internal deficit to environmental mismatch and calls for approaches that are ethically reflective, relational, and grounded in lived experience.

Bringing this ethos into the therapy room means more than just intellectual alignment. It demands visible, embodied shifts. Inviting movement, using visual cues or joint writing, slowing the pace, or tolerating non-linear dialogue are all simple yet powerful gestures (Conway, 2012, pp. 410–411). They communicate presence and inclusion, creating space for identity to be reclaimed. For many adults, an ADHD diagnosis is less a clinical label than a profound re-evaluation of self. Kapp (2020) observes that while diagnostic labels can provide relief and meaning, they can also prompt people to re-evaluate past experiences and social expectations (pp. 11–13).

In turn, therapists are invited to adopt a posture of reflexivity and openness, resisting narrow outcome metrics (Fonagy & Target, 2002, pp. 311–312; Conway, 2012, pp. 410–411). Conway (2012) cautions that when therapeutic success is defined purely in terms of behavioural compliance or organisational gains, clinicians risk imposing neurotypical standards (p. 410). Affirming practice, by contrast, is collaborative and rights-based, with inclusion, autonomy, and

shared meaning-making at its centre. This may involve adjusting sensory conditions, co-creating flexible goals, and inviting clients to shape the pace and process of therapy (Conway, 2012, pp. 410–411). In this way, therapy becomes a regulating relationship that supports both self-regulation and narrative expansion, without enforcing external norms (Fonagy & Target, 2002, pp. 311–312).

Ultimately, identity is not built in isolation but in relationship. It arises not from correction but from contact with a regulating other who affirms the client’s affective truth. Drawing on attachment research, Fonagy and Target (2002) cite experimental work with rat pups by Polan and Hofer (1999), who observed that proximity to the caregiver shapes both physiology and behaviour. As Polan and Hofer note, “the relationship thus provides an opportunity for the mother to shape both the developing physiology and the behavior of her offspring, through her patterned interactions with the infant” (p. 177). Longitudinal studies with humans similarly show that capacities for effortful control, which are core to self-regulation, emerge early and remain relatively stable, highlighting the foundational role of dyadic interaction (Fonagy & Target, 2002, p. 318). Within psychotherapy, attuned relational presence enables masked or silenced parts of the self to emerge, not as symptoms to be fixed but as aspects seeking recognition (Conway, 2012, pp. 410–411).

4.5 Chapter Discussion: Relational Repair, Affect, and Narrative Integration

This chapter has argued that for many adults with ADHD, therapeutic change begins not with behavioural strategies, but with the slow, relational work of being seen. Years of misattunement, masking, and rejection often leave clients disconnected from their emotional lives, unsure of which parts are permitted to show up in the room (Middleton et al., 2024;

Conway, 2012). A neurodiversity-affirming stance does not pathologise such responses as resistance. Instead, it meets these histories with pacing, patience, and structural flexibility. As Conway (2012, pp. 410–411) notes, adaptations to format, pacing, or sensory conditions are not merely logistical, but relational signals that difference is not only tolerated, but welcomed.

Within such safety, affect becomes a site of change. When emotion is mirrored rather than pathologised, previously silenced states can surface and be integrated, allowing new forms of self-regulation and connection to emerge (Fonagy & Target, 2002, pp. 311–312; Conway, 2012). This process is rarely linear, and its outcomes may not conform to neurotypical ideals of progress. Nevertheless, these shifts matter. As Kapp (2020) emphasises, inclusion and autonomy are not end goals but conditions under which identity can unfold and meaning can be made.

Narrative re-authoring often marks this transition. Clients begin to revise internalised scripts shaped by shame and perceived failure, not by discarding them, but by weaving them into a broader, more compassionate story of self (Yergeau, 2018, p. 1; Chapman, 2021). In this way, therapy moves beyond symptom correction, offering instead a space for relational repair, self-understanding, and dignity.

CHAPTER FIVE: Conclusion: Re-authoring Adult ADHD - From Pathology to Relational Possibility

“My experience is what I agree to attend to. Only those items which I notice shape my mind.”
- William James, *The Principles of Psychology* (1890/2017, p. 169)

Adult ADHD has long been appraised through a *deficit* lens that prizes productivity and self-control (Timimi & Taylor, 2004; Conrad & Bergey, 2014). The present thesis asked what comes into view when those evaluative habits are suspended and the cultural, relational and affective textures of divergent attention are brought to the fore. In response, it traced the discursive history of the diagnosis, explored the emotional lives of late-recognised adults and advanced a psychotherapeutic framework in which co-regulation, stigma literacy and intersectional justice are inseparable. The discussion below brings these strands together, clarifies how the study meets its aim and objectives, acknowledges its limitations, and identifies urgent next steps.

The analysis first unsettled the apparent neutrality of diagnostic language. The journey from minimal brain dysfunction to neurodevelopmental disorder (Barkley, 2015) reads less as scientific progress than as a record of biopolitical anxiety over how bodies attend, sit still and generate value (Foucault, 1977). Even the ostensibly global ICD-11 remains tethered to Western norms of efficiency and individual responsibility (World Health Organization, 2022). As Timimi and Taylor (2004) caution, any label forged in such a climate risks treating conformity as health.

Stigma then emerged as both narrative and material force. Media caricatures, gendered myths, and neoliberal pressures to ‘optimise’ consolidate shame and self-blame (Bisset et al., 2021). Structural inequities compound the harm: race, class and criminal-justice involvement powerfully shape who is diagnosed, medicated or punished (Young et al., 2014). Lived accounts

examined here show that many adults greet diagnosis with simultaneous relief and entry into a fresh regime of scrutiny.

Emotion sits at the centre of those accounts. A growing evidence base identifies affective lability, rejection sensitivity and shame as central, rather than secondary, dimensions of adult ADHD (Faraone et al., 2019; Soler-Gutiérrez et al., 2023). As Rosier (2025) observes, ‘Folks, you’re not broken, you’re quirky, but you’re not broken’ (02:38–02:44), a formulation that counters shame by reframing difference as value-neutral variation. Chronic masking stretches self-monitoring to the point of exhaustion, leaving individuals, in Raymaker et al. 's (2020) words, ‘with no clean-up crew’ (p. 132). Yet, as Hull et al. (2017) show, camouflaging can also be read as an act of social creativity rather than wilful deviance, and such a re-reading marks the first step towards relational repair.

Therapeutically, that repair is cultivated not through corrective drills but through attuned, co-regulated alliance. Attachment-informed and mentalization-based practices invite clients to discover alternative tempos of thinking, feeling and moving in the presence of an other who neither pathologises nor romanticises difference (Bateman & Fonagy, 2016; Schore, 2012). Pragmatically, this may involve pacing sessions to bodily cues, validating doodling or walking as legitimate forms of reflection, and naming systemic bias when it enters the room. Compassion research confirms that such validation lowers threat arousal and broadens cognitive repertoire (Germer & Neff, 2013).

Theoretically, the thesis contributes to a social-psychoanalytic lens. Foucauldian discourse analysis charts the outer architecture of power; Lacanian theory shows how certain attentional styles fall outside the Symbolic and become unintelligible within dominant meaning

systems (Lacan, 2002). The neurodiversity paradigm, meanwhile, insists on dignity, rights and collective redesign (Walker, 2021). Together, these perspectives recast ADHD as a knot where biology, culture and relationship meet, rather than a fault line within an individual brain. In doing so, the study fulfils its aim: to articulate a relational, neurodiversity-affirming framework. It also satisfies its objectives: mapping the discourses that shape adult ADHD and clarifying how emotional dysregulation informs psychotherapeutic practice.

Every lens, however, illuminates some features while obscuring others. The analysis relies on English-language literature and digitally mediated narratives; no primary interviews or quantitative outcome data were gathered. Reflexive journals and peer debriefs, forms of ‘memoing’ that document and question the researcher’s assumptions (Finlay, 2002), mitigated but did not eliminate positional bias. These boundaries underscore a wider gap: the scarcity of research on relational and affect-focused interventions compared with the wealth of biomedical trials (Philipsen, 2012; Seery et al., 2024).

That gap points towards future work. Co-produced, mixed-methods trials of relational or mentalization-based therapies could establish clinical validity beyond symptom-reduction protocols (Bateman & Fonagy, 2016; Philipsen, 2012; Seery et al., 2024). Cross-cultural investigations, such as comparative symptom studies in Japan and the United States or ethnographies of Japanese psychiatry, could reveal how non-Western epistemologies construe attention, loosening the grip of productivity myths (Davis et al., 2012; Kitanaka, 2012). Longitudinal studies that trace affective trajectories among women, LGBTQ+ people, and racialised communities remain scarce. However, emerging qualitative work with multiply marginalised adults points to both the need and feasibility of such designs (Beun, 2025, Visser et

al., 2024). Finally, policy scholarship should evaluate Universal Design for Learning and other universal-access models as public-health measures rather than discretionary concessions (Rose & Meyer, 2006).

Psychotherapy can be the seedbed of broader cultural change. When clinician and client meet as two subjects rather than one expert and one problem, self-regulation grows out of co-regulation and difference becomes a shared resource (Bateman & Fonagy, 2016). The same logic is emerging beyond the consulting room: some forward-looking employers, including SAP, Microsoft and EY, now run neurodiversity recruitment initiatives that value the attentional styles often labelled ADHD for their imaginative reach (Austin & Pisano, 2017). If success in therapy were measured by mutual responsiveness rather than compliance, and if schools and public services embraced the creative energies these employers have begun to recognise, how might our social architecture change? Such questions invite research, policy and practice to move from fixing attention to redesigning environments so that varied forms of attention and difference can flourish.

“All actual life is encounter.”

Martin Buber, *I and Thou* (1970, p. 62)

REFERENCES

- Abdelnour, E., Jansen, M. O., & Gold, J. A. (2022). ADHD diagnostic trends: Increased recognition or overdiagnosis? *Missouri Medicine*, *119*(5), 467–473.
- Abraham, A., Windmann, S., Siefen, R., Daum, I., & Güntürkün, O. (2006). Creative thinking in adolescents with attention deficit hyperactivity disorder (ADHD). *Child Neuropsychology*, *12*(2), 111-123. <https://doi.org/10.1080/09297040500320691>
- Adshead, G., & Horne, E. (2021). *The devil you know: Stories of human cruelty and compassion*. Scribner.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishing.
- Ando, S., Yamaguchi, S., Aoki, Y., & Thornicroft, G. (2013). Review of mental-health-related stigma in Japan. *Psychiatry and Clinical Neurosciences*, *67*(7), 471–482. <https://doi.org/10.1111/pcn.12086>
- Antshel, K. M., Zhang-James, Y., & Faraone, S. V. (2013). The comorbidity of ADHD and autism spectrum disorder. *Expert Review of Neurotherapeutics*, *13*(10), 1117–1128. <https://doi.org/10.1586/14737175.2013.840417>
- Asherson, P., Buitelaar, J., Faraone, S. V., & Rohde, L. A. (2016). Adult attention-deficit hyperactivity disorder: Key conceptual issues. *The Lancet Psychiatry*, *3*(6), 568–578. [https://doi.org/10.1016/s2215-0366\(16\)30032-3](https://doi.org/10.1016/s2215-0366(16)30032-3)
- Austin, R. D., & Pisano, G. P. (2017). Neurodiversity as a competitive advantage. *Harvard Business Review*, *95*(3), 96–103.
- Babinski, D., Pelham, W., Molina, B., Waschbusch, D., Gnagy, E., Yu, J., ... & Biswas, A. (2011). Women with childhood ADHD: Comparisons by diagnostic group and gender.

- Journal of Psychopathology and Behavioral Assessment*, 33(4).
<https://doi.org/10.1007/s10862-011-9247-4>
- Barkley, R. A. (2006). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment*. Guilford Press.
- Barkley, R. A., Murphy, K. R., & Fischer, M. (2007). *ADHD in adults: What the science says*. Guilford Press.
- Barkley, R. A. (2015). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (4th ed.)*. The Guilford Press.
- Bateman, A., & Fonagy, P. (2010). Mentalization based treatment for borderline personality disorder. *World psychiatry*, 9(1), 11.
- Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: A practical guide*. Oxford University Press.
- Bedrossian, L. (2021). Understand and address complexities of rejection sensitive dysphoria in students with ADHD. *Disability Compliance for Higher Education*, 26(10), 4.
- Berlant, L. G. (2011). *Cruel optimism*. Duke University Press.
- Bergey, M. (2024). "Pills Don't Teach Skills": ADHD Coaching, Identity Work, and the Push toward the Liminal Medicalization of ADHD. *Journal of Health and Social Behavior*, 65(2), 256-272. <https://doi.org/10.1177/00221465231220385>
- Beun, S. G. (2025). *At the intersection of LGBTQIA+ and ADHD: The lived experiences of multiply marginalised individuals* (Doctoral dissertation, Rutgers, The State University of New Jersey). ProQuest Dissertations Publishing.

- Bisset, M., Winter, L., Middeldorp, C., Coghill, D., Zendarski, N., Bellgrove, M., ... & Sciberras, E. (2021). Recent attitudes toward ADHD in the broader community: A systematic review. *Journal of Attention Disorders*, 26(4), 537–548.
<https://doi.org/10.1177/10870547211003671>
- Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. Routledge
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Buber, M. (1970). *I and Thou* (W. Kaufman, Trans.). Scribner. (Original work published 1923)
- Chang, C. C., Chen, Y. M., Liu, T. L., Hsiao, R. C., Chou, W. J., & Yen, C. F. (2020). Affiliate stigma and related factors in family caregivers of children with attention-deficit/hyperactivity disorder. *International Journal of Environmental Research and Public Health*, 17(2), 576.
- Chapman, R. (2021). Neurodiversity and the Social Ecology of Mental Functions. *Perspectives on Psychological Science*, 16(6), 1360-1372. <https://doi.org/10.1177/1745691620959833>
- Clarkson, P., & Pokorny, M. (Eds.). (1994). *The handbook of psychotherapy*. Routledge.
- Conrad, P., & Bergey, M. R. (2014). The impending globalisation of ADHD: Notes on the expansion and growth of a medicalised disorder. *Social Science & Medicine*, 122, 31–43.
<https://doi.org/10.1016/j.socscimed.2014.10.019>
- Conway, F. (2012). Psychodynamic psychotherapy of ADHD: A review of the literature. *Psychotherapy*, 49(3), 404–417. <https://doi.org/10.1037/a0027344>
- Cosgrove, L. and Karter, J. (2018). The poison in the cure: neoliberalism and contemporary movements in mental health. *Theory & Psychology*, 28(5), 669-683.
<https://doi.org/10.1177/0959354318796307>

- Crary, J. (2013). *24/7: Late capitalism and the ends of sleep*. Verso Books.
- Crawford, M. B. (2015). *The world beyond your head: On becoming an individual in an age of distraction*. Penguin Canada.
- Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics*. University of Chicago Legal Forum, 1989(1), 139–167.
- Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, 43(6), 1241–1299.
<https://doi.org/10.2307/1229039>
- Davis, J. M., Takahashi, T., Shinoda, H., & Gregg, N. (2012). Cross-cultural comparison of ADHD symptoms among Japanese and US university students. *International Journal of Psychology*, 47(3), 203–210. <https://doi.org/10.1080/00207594.2011.614617>
- Druehdahl, L. C., & Sporrang, S. K. (2020). More than meets the eye: A Foucauldian perspective on treating ADHD with medicine. *Research in Social and Administrative Pharmacy*, 16(9), 1201–1207. <https://doi.org/10.1016/j.sapharm.2019.12.008>
- Erskine, R. G., & Moursund, J. P. (2011). *Integrative psychotherapy in action*. Routledge.
<https://doi.org/10.4324/9780429476020>
- Evans, D. (1996). *An introductory dictionary of Lacanian psychoanalysis*. Routledge.
- Farooq, R., Emerson, L., Keoghan, S., & Adamou, M. (2015). Prevalence of adult ADHD in an all-female prison unit. *ADHD Attention Deficit and Hyperactivity Disorders*, 8(2), 113–119. <https://doi.org/10.1007/s12402-015-0186-x>
- Faraone, S. V., Rostain, A. L., Blader, J., Busch, B., Childress, A. C., Connor, D. F., & Newcorn, J. H. (2019). Practitioner Review: Emotional dysregulation in

- attention-deficit/hyperactivity disorder – implications for clinical recognition and intervention. *Journal of Child Psychology and Psychiatry*, 60(2), 133–150.
<https://doi.org/10.1111/jcpp.12899>
- Finlay, L. (2002). “Outing” the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research*, 12(4), 531–545.
<https://doi.org/10.1177/104973202129120052>
- Fisher, M. (2009). *Capitalist realism: Is there no alternative?* Zero Books.
- Flanigan, L. K. (2021). *I do not have stigma towards people with ADHD (but I do think they're lazy): Using education and experience to reduce negative attitudes towards ADHD* (Doctoral thesis, University of Calgary). PRISM: University of Calgary's Digital Repository. <https://prism.ucalgary.ca/handle/1880/113101>
- Fonagy, P., & Luyten, P. (2018). Attachment, mentalizing, and the self. In W. J. Livesley & R. Larstone (Eds.), *Handbook of personality disorders: Theory, research, and treatment* (2nd ed., pp. 123–140). The Guilford Press.
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. Other Press.
- Fonagy, P., & Target, M. (2002). Early intervention and the development of self-regulation. *Psychoanalytic Inquiry*, 22(3), 307–335. <https://doi.org/10.1080/07351692209348990>
- Foucault, M. (1977). *Discipline and punish: The birth of the prison*. Pantheon Books.
- Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings, 1972–1977*. Pantheon Books.
- Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of clinical psychology*, 69(8), 856-867.

- Ginsberg, Y., Quintero, J., Anand, E., Casillas, M., & Upadhyaya, H. P. (2014). Underdiagnosis of attention-deficit/hyperactivity disorder in adult patients: a review of the literature. *The Primary Care Companion for CNS Disorders*, 16(3), Article PCC.13r01600. <https://doi.org/10.4088/PCC.13r01600>
- Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment*, 15(3), 199-208. <https://doi.org/10.1192/apt.bp.107.005264>
- Godfrey, E., Fuermaier, A. B., Tucha, L., Butzbach, M., Weisbrod, M., Aschenbrenner, S., & Tucha, O. (2021). Public perceptions of adult ADHD: Indications of stigma?. *Journal of Neural Transmission*, 128(7), 993-1008. <https://doi.org/10.1007/s00702-020-02279-8>
- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.
- Goldstein, S. A. (2005). Coaching as a treatment for ADHD. [Editorial]. *Journal of Attention Disorders*, 9, 379-381. <http://jad.sagepub.com>
- Gudjónsson, G., Sigurðsson, J., Sigfúsdóttir, I., & Young, S. (2012). A national epidemiological study of offending and its relationship with ADHD symptoms and associated risk factors. *Journal of Attention Disorders*, 18(1), 3–13. <https://doi.org/10.1177/1087054712437584>
- Hallowell, E. M., & Ratey, J. J. (2011). *Driven to distraction (revised): Recognizing and coping with attention deficit disorder*. Anchor.
- Hallowell, E. M., & Ratey, J. J. (2021). *ADHD 2.0: New science and essential strategies for thriving with distraction, from childhood through adulthood*. Ballantine Books.
- Hallowell, E. M. (Guest), & Partridge, A. (Host). (2024, November 5). *The No.1 ADHD expert: How to master your ADHD – Dr Ned Hallowell* [Audio podcast episode]. In *ADHD Chatter*. YouTube. <https://www.youtube.com/watch?v=LZacXMqMSG8>

- Hayashi, K., Nakamura, K., Takahashi, T., & Tsujii, M. (2019). Clinical characteristics of women with ADHD in Japan. *Neuropsychiatric Disease and Treatment*, *15*, 3051–3061.
<https://doi.org/10.2147/NDT.S227770>
- Hinshaw, S. P., & Ellison, K. (2015). *ADHD: What everyone needs to know*. Oxford University Press.
- Hinshaw, S. P., Nguyen, P. T., O’Grady, S. M., & Rosenthal, E. A. (2021). Annual research review: Attention-deficit/hyperactivity disorder in girls and women: Underrepresentation, longitudinal processes, and key directions. *Journal of Child Psychology and Psychiatry*, *63*(4), 484–496. <https://doi.org/10.1111/jcpp.13480>
- Hirsch, O., Chavanon, M. L., Riechmann, E., Christiansen, H., & Wüst, S. (2018). Emotional dysregulation is a primary symptom in adult attention-deficit/hyperactivity disorder (ADHD). *Journal of Affective Disorders*, *232*, 41–47.
<https://doi.org/10.1016/j.jad.2018.02.011>
- Hull, L., Petrides, K. V., Allison, C., Smith, P., Baron-Cohen, S., Lai, M.-C., & Mandy, W. (2017). “Putting on my best normal”: Social camouflaging in adults with autism spectrum conditions. *Journal of Autism and Developmental Disorders*, *47*(8), 2519–2534.
<https://doi.org/10.1007/s10803-017-3166-5>
- Ishikawa, H., Kawakami, N., & Kessler, R. (2015). Lifetime and 12-month prevalence, severity and unmet need for treatment of common mental disorders in Japan: Results from the final dataset of World Mental Health Japan Survey. *Epidemiology and Psychiatric Sciences*, *25*(3), 217–229. <https://doi.org/10.1017/s2045796015000566>
- James, W. (2017). *The principles of psychology* (Vols. 1–2, Complete and unabridged). Pantianos Classics. (Original work published 1890).

- Kanehara, A., Umeda, M., & Kawakami, N. (2015). Barriers to mental health care in Japan: Results from the World Mental Health Japan Survey. *Psychiatry and Clinical Neurosciences*, 69(9), 523–533. <https://doi.org/10.1111/pcn.12267>
- Kapp, S. K. (2020). *Autistic community and the neurodiversity movement: Stories from the frontline*. Springer Nature. <https://link.springer.com/book/10.1007/978-981-13-8437-0>
- Kellison, I., Bussing, R., Bell, L., & Garvan, C. (2010). Assessment of stigma associated with attention-deficit hyperactivity disorder: Psychometric evaluation of the ADHD Stigma Questionnaire. *Psychiatry Research*, 178(2), 363–369.
- Khorsandi, S. (2023). *Scatter brain: How I finally got off the ADHD rollercoaster and became the owner of a very tidy sock drawer*. Vermilion.
- Kincheloe, J. L. (2001). Describing the bricolage: Conceptualizing a new rigor in qualitative research. *Qualitative Inquiry*, 7(6), 679–692.
<https://doi.org/10.1177/107780040100700601>
- Kitanaka, J. (2012). *Depression in Japan: Psychiatric cures for a society in distress*. Princeton University Press.
- Kubik, J. (2010). Efficacy of ADHD coaching for adults with ADHD. *Journal of Attention Disorders*, 13(5), 442-453. <https://doi.org/10.1177/1087054708329960>
- Lacan, J. (2002). *Écrits: A selection* (B. Fink, Trans.). W. W. Norton & Company. (Original work published 1966).
- Layton, L. (2020). *Toward a social psychoanalysis: Culture, character, and normative unconscious processes*. Routledge.

- Leitner, Y. (2014). The co-occurrence of autism and attention deficit hyperactivity disorder in children – what do we know? *Frontiers in Human Neuroscience*, 8, 268.
<https://doi.org/10.3389/fnhum.2014.00268>
- Lloyd, T. (Guest), & Partridge, A. (Host). (2025, March 11). *Europe's No.1 ADHD doctor: Women deserved better! | Dr Tony Lloyd PhD* [Audio podcast episode]. In *ADHD Chatter*. YouTube. <https://www.youtube.com/watch?v=qL6-qPYL0eo&t=353s>
- Lorde, A. (2007). *Sister outsider: Essays and speeches*. Ten Speed Press. (Original work published 1984).
- Maté, G. (1999). *Scattered minds: The origins and healing of attention deficit disorder*. Vintage Canada.
- Maté, G. (2022). *The myth of normal: Trauma, illness and healing in a toxic culture*. Penguin Random House.
- McCabe, J. (2024). *How to ADHD: An insider's guide to working with your brain (not against it)*. Penguin.
- McCoy, S. (2023). *A discourse analysis of Lacanian psychoanalysts' conceptualisation of child psychopathology* (Doctoral dissertation). Dublin City University.
- Middleton, E. (Guest), & Partridge, A. (Host). (2024 September 17). *I masked for too long!* [Audio podcast episode]. In *ADHD Chatter*. YouTube.
<https://www.youtube.com/watch?v=u-Qtf9YAIts>
- Middleton, E., Khorsandi, S., Brown, K., & Duguid, S. (Guests), & Partridge, A. (Host). (2024, December 24). *4 late diagnosed ADHD women share life hacks | Christmas special* [Audio podcast episode]. In *ADHD Chatter*. YouTube.
<https://www.youtube.com/watch?v=R-ObJnkbCOY>

- Moth, R. (2018). ‘The business end’: Neoliberal policy reforms and biomedical residualism in frontline community mental health practice in England. *Competition & Change*, 24(2), 133–153. <https://doi.org/10.1177/1024529418813833>
- Moncrieff, J. (2008). *The myth of the chemical cure: A critique of psychiatric drug treatment*. Palgrave Macmillan.
- Mowlem, F. D., Rosenqvist, M. A., Martin, J., Lichtenstein, P., Asherson, P., & Larsson, H. (2019). Sex differences in predicting ADHD clinical diagnosis and pharmacological treatment. *European Child & Adolescent Psychiatry*, 28(4), 481–489. <https://doi.org/10.1007/s00787-018-1211-3>
- Mueller, A. K., Fuermaier, A. B. M., Koerts, J., & Tucha, L. (2012). Stigma in attention deficit hyperactivity disorder. *ADHD Attention Deficit and Hyperactivity Disorders*, 4(3), 101–114. <https://doi.org/10.1007/s12402-012-0085-3>
- Nicholson, R. (2025, May 12). Inside Our ADHD Minds review – Chris Packham’s revelatory show could not be more crucial. *The Guardian*. <https://www.theguardian.com/tv-and-radio/2025/may/12/inside-our-adhd-minds-review-chris-packhams-revelatory-show-couldnt-be-more-crucial>
- North, P. (2011). *The problem of distraction*. Stanford University Press.
- Organisation for Economic Co-operation and Development (OECD). (2019). *Health at a glance 2019: OECD indicators*. OECD Publishing. <https://doi.org/10.1787/4dd50c09-en>
- O’Kane, O. (Guest), & Partridge, A. (Host). (2024, April 23). *How to stop worrying about anxiety | Owen O’Kane* [Audio podcast episode]. In *ADHD Chatter*. YouTube. https://www.youtube.com/watch?v=ZjqzaU8r0_Q

- Parker, I. (2004). *Qualitative psychology: Introducing radical research*. McGraw-Hill Education (UK).
- Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *The Lancet*, *369*(9569), 1302–1313.
[https://doi.org/10.1016/S0140-6736\(07\)60368-7](https://doi.org/10.1016/S0140-6736(07)60368-7)
- Pink, S., & Pink, R. (2024). *Small talk: 10 ADHD lies and how to stop believing them*. Penguin Random House
- Philipsen, A. (2012). Psychotherapy in adult attention deficit hyperactivity disorder: implications for treatment and research. *Expert Review of Neurotherapeutics*, *12*(10), 1217–1225.
<https://doi.org/10.1586/ern.12.91>
- Polan, H. J., & Hofer, M. A. (1999). Psychobiological origins of infant attachment and separation responses. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 162–180). Guilford Press.
- Quinn, P. O., & Madhoo, M. (2014). A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis. *The primary care companion for CNS disorders*, *16*(3), 27250. <https://doi.org/10.4088/PCC.13r01596>
- Rackley, M. (Guest), & Partridge, A. (Host). (2024, May 14). *The psychologist with 20 years ADHD & autism experience reveals 3 Signs of AuDHD* | Dr Mark Rackley [Audio podcast episode]. In ADHD Chatter. YouTube.
<https://www.youtube.com/watch?v=BIK2U7M5QOE>
- Ramsay, J. R., & Rostain, A. L. (2007). Psychosocial treatments for attention-deficit/hyperactivity disorder in adults: Current evidence and future directions. *Professional Psychology: Research and Practice*, *38*, 338-346.

- Ratey, N. A. (2008). *The disorganized mind: Coaching your ADHD brain to take control of your time, tasks, and talents*. New York: St. Martin's Press.
- Raymaker, D. M., Teo, A. R., Steckler, N. A., Lentz, B., Scharer, M., Delos Santos, A., Arnold, S. R. C., & Nicolaidis, C. (2020). "Having all of your internal resources exhausted beyond measure and being left with no clean-up crew": Defining autistic burnout. *Autism in Adulthood*, 2(2), 132–143. <https://doi.org/10.1089/aut.2019.0079>
- Retz, W., Stieglitz, R. D., Corbisiero, S., Retz-Junginger, P., & Rösler, M. (2012). Emotional dysregulation in adult ADHD: what is the empirical evidence? *Expert Review of Neurotherapeutics*, 12(10), 1241–1251. <https://doi.org/10.1586/ern.12.109>
- Retz-Junginger, P., Rösler, M., Jacob, C., Alm, B., & Retz, W. (2010). Gender differences in self- and investigator-rated psychopathology in adult attention-deficit/hyperactivity disorder. *ADHD Attention Deficit and Hyperactivity Disorders*, 2(2), 93–101. <https://doi.org/10.1007/s12402-010-0024-0>
- Rogers, C. R. (1980). *A way of being*. Houghton Mifflin.
- Rose, D. H., & Meyer, A. (2006). *A practical reader in Universal Design for Learning*. Harvard Education Press.
- Rose, N. (2019). *Our psychiatric future: The politics of mental health*. Polity Press.
- Rosier, T. (Guest), & Partridge, A. (Host). (2025, May 1). *Leading ADHD expert shares new emotional dysregulation trick* [Audio podcast episode]. In *ADHD Chatter*. YouTube. <https://www.youtube.com/watch?v=38nBvOtgH-I>
- Rucklidge, J. J. (2010). Gender differences in attention-deficit/hyperactivity disorder. *Psychiatric Clinics of North America*, 33(2), 357–373. <https://doi.org/10.1016/j.psc.2010.01.006>

- Salomonsson, B. (2017). Interpreting the inner world of ADHD children: Psychoanalytic perspectives. *International Journal of Qualitative Studies on Health and Well-Being*, 12 (sup1). <https://doi.org/10.1080/17482631.2017.1298269>
- Santiago, C. D., Kaltman, S., & Miranda, J. (2012). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, 69(2), 115–126. <https://doi.org/10.1002/jclp.21951>
<https://pubmed.ncbi.nlm.nih.gov/23280880/>
- Scanlon, C., & Adlam, J. (2013). Reflexive violence. *Psychoanalysis, Culture & Society*, 18(3), 223–241. <https://doi.org/10.1057/pcs.2013.2>
- Schore, A. N. (2012). *The science of the art of psychotherapy*. W. W. Norton & Company.
- Seery, C., Leonard-Curtin, A., Naismith, L., King, N., O'Donnell, F., Byrne, B., ... Bramham, J. (2024). Feasibility of the understanding and managing adult ADHD programme: open-access online group psychoeducation and acceptance and commitment therapy for adults with attention-deficit hyperactivity disorder. *BJPsych Open*, 10(5), e163.
<https://doi.org/10.1192/bjo.2024.743>
- Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. *American Journal of Psychiatry*, 171(3), 276-293.
<https://doi.org/10.1176/appi.ajp.2013.13070966>
- Singh, I. (2011). A disorder of anger and aggression: Children's perspectives on attention deficit/hyperactivity disorder in the UK. *Social Science & Medicine*, 73(6), 889–896.
<https://doi.org/10.1016/j.socscimed.2011.03.049>
- Sonuga-Barke, E., Cortese, S., Fairchild, G., & Stringaris, A. (2016). Trans-diagnostic neuroscience of child and adolescent mental disorders: Differentiating decision-making in

- attention-deficit/hyperactivity disorder, conduct disorder, depression and anxiety. *Journal of Child Psychology and Psychiatry*, 57(3), 321–349.
- Soler-Gutiérrez, A. M., Pérez-González, J. C., & Mayas, J. (2023). Evidence of emotion dysregulation as a core symptom of adult ADHD: A systematic review. *Plos one*, 18(1), e0280131. <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0280131>
- St. Pierre, E. A. (2024). Post qualitative research: The critique and the coming after (from the fourth edition). In N. K. Denzin, Y. S. Lincoln, M. D. Giardina, & G. S. Cannella (Eds.), *The SAGE Handbook of Qualitative Research (6th ed.)*. SAGE Publications, Incorporated.
- Timimi, S., & Taylor, E. (2004). ADHD is best understood as a cultural construct. *British Journal of Psychiatry*, 184(01), 8–9. <https://doi.org/10.1192/bjp.184.1.8>
- Tracy, S. J. (2010). Qualitative quality: Eight “big-tent” criteria for excellent qualitative research. *Qualitative Inquiry*, 16(10), 837–851. <https://doi.org/10.1177/1077800410383121>
- Twomey, C. (2025). We need to change the narrative! [Video]. ADHD Connections. <https://www.adhdconnections.ie/resources>. [Posted March 3, 2025].
- Vélez-Pastrana, M., González, R., Ramos-Fernández, A., Padilla, R., Levin, F., & García, C. (2020). Attention deficit hyperactivity disorder in prisoners: Increased substance use disorder severity and psychiatric comorbidity. *European Addiction Research*, 26(4–5), 179–190. <https://doi.org/10.1159/000508829>
- Visser, M. J., Peters, R. M., & Luman, M. (2024). Understanding ADHD-related stigma: A gender analysis of young adults and key stakeholder perspectives. *Neurodiversity*, 2, 27546330241274664. <https://doi.org/10.1177/27546330241274664>

- Walker, N. (2021). *Neuroqueer heresies: Notes on the neurodiversity paradigm, autistic empowerment, and postnormal possibilities*. Autonomous Press.
- Wallin, D. J. (2007). *Attachment in psychotherapy*. Guilford Press.
- Wender, P. H. (1998). Attention-deficit hyperactivity disorder in adults. *Psychiatric Clinics of North America*, 21(4), 761-774.
- Wilkins, P. (2010). Unconditional positive regard reconsidered. *British Journal of Guidance & Counselling*, 28(1), 23-36. <https://doi.org/10.1080/030698800109592>
- Winnicott, D. W. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. Hogarth Press.
- World Health Organization. (2022). *International Classification of Diseases, 11th Revision (ICD-11)*. <https://icd.who.int/en>
- Wythoff, G. (Ed.). (2016). *The perversity of things: Hugo Gernsback on media, tinkering, and scientifiction* (Vol. 52). University of Minnesota Press.
- Yalom, I. D. (1980). *Existential psychotherapy*. Basic Books.
- Yergeau, M. (2018). *Authoring autism: On rhetoric and neurological queerness*. Duke University Press.
- Yeung, A., Ng, E., & Abi-Jaoude, E. (2022). TikTok and attention-deficit/hyperactivity disorder: A cross-sectional study of social media content quality. *The Canadian Journal of Psychiatry*, 67(12), 899–906. <https://doi.org/10.1177/07067437221082854>
- Young, S., Cocallis, K.M. (2019). Attention deficit hyperactivity disorder (ADHD) in the prison system. *Current Psychiatry Reports* 21(6), Article 41. <https://doi.org/10.1007/s11920-019-1022-3>

Young, S., Moss, D., Sedgwick, O., Fridman, M., & Hodgkins, P. (2014). A meta-analysis of the prevalence of attention deficit hyperactivity disorder in incarcerated populations.

Psychological Medicine, 45(2), 247–258. <https://doi.org/10.1017/s0033291714000762>

Young, S., Sedgwick, O., Fridman, M., Gudjónsson, G., Hodgkins, P., Lantigua, M., ... & González, R. (2015). Co-morbid psychiatric disorders among incarcerated ADHD populations: A meta-analysis. *Psychological Medicine*, 45(12), 2499–2510.

<https://doi.org/10.1017/s0033291715000598>

Young, S., Adamo, N., Ásgeirsdóttir, B. B., Branney, P., Beckett, M., Colley, W., ... Woodhouse, E. (2020). Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of

attention-deficit/hyperactivity disorder in girls and women. *BMC Psychiatry*, 20(1).

<https://doi.org/10.1186/s12888-020-02707-9>