Focusing on the Voices of Adults Diagnosed with 'Attention Deficit Hyperactivity Disorder'

Síona Bastable Vizzard

B.A. (Mod.), M.A., Dip. Psych. (Open), Clin. Dip. in Integrative Psychotherapy

Middlesex University and Metanoia Institute

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Abstract

The aim of this work was to allow the voices of adults who identified with Attention Deficit Hyperactivity Disorder ('ADHD') to be heard and to contribute qualitative findings in a field heavily influenced by quantitative research. A further aim was to elicit therapeutic guidelines to add to and inform clinical practice in the field of counselling psychology.

Using open-ended and informally structured questions, three interviews each were held with six participants, four men and two women. None of the participants had been formally diagnosed with 'ADHD' until their adulthood but all identified strongly with the characteristics of the condition. Narrative research methodology was used to explore participant transcripts holding the perspectives of temporality, sociality, place and adding a fourth – relationality, in mind. Participant narratives were presented in terms of their life story, their experience of 'ADHD' and the impact of both on their sense of themselves.

Participants felt strongly that while the symptoms they experienced as a result of 'ADHD' had influenced and shaped what they saw as often dysfunctional relationships with self and others, they also acknowledged that early emotional trauma, neglect, and interpersonal dysfunction had played a part in their self-development. Their capacity to differentiate between themselves and behaviours driven by the neurological consequences of mistuned neural networks was compromised and resulted in damage to self-perception, self-esteem, self-confidence and self-worth. All participants were also aware of a capacity for divergent thinking that allowed some of their personal skills and talents to be productively exercised, particularly occupationally. Based on the findings a series of therapeutic guidelines were drawn up to inform clinical practice with this group. Limitations of this work were noted along with suggestions for further research projects.

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Focusing on the Voices of Adults Diagnosed with 'Attention-Deficit-Hyperactivity Disorder'

Introduction

Motivation for the study

> *"Imagine that you crawled on your knees your whole life, but everybody around you walked on two legs. You recognize that you are different, and you know you should be walking like everyone else, but you just can't keep your balance on two legs the way you can when you crawl."*
>
> *(Ashley, adult with 'ADHD', in ADDitude online magazine 2013)*

My interest in 'ADHD' stems from the diagnosis of my now 32-year-old son with 'mild to moderate' Attention Deficit Hyperactivity Disorder ('ADHD')[1] in the United States (US) when he was 7 years old. I had grown up in the parochial, Catholic, sceptical-of-psychology world of Dublin, Ireland in the 1950s and 60s. As a young adult my passion was learning, and my focus was literature. I had broadened my horizons by spending some years in graduate school in Canada, where I met and married a 6' 7" Californian and went to live in the US. When my son was diagnosed, I did not know how to access, either internally or externally, the kinds of resources I needed to really understand what he and I, as his parent, were dealing with. Though I did not realize it at the time, the moment I witnessed something of the fundamental difference between how a person with 'ADHD' experiences the world, was when I was trying to feed my somewhere-between-12-and-16-month-old son and could not

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[1] In the medical model, adult ADHD is diagnosed based on heterogeneous behaviours that exist on a spectrum. Calling it a 'deficit' and a 'disorder' is pathologizing. In this work, I place the abbreviation 'ADHD' in inverted commas, wishing to keep a focus on the constructed nature of the terminology used to describe the condition.

get him to focus on eating – a basic survival instinct - unless he was also playing with a toy car at the same time. Doing the latter was what was it seemed to take for him to be able to access the former. It had taken hours of trial and error, frustration, creative thinking and numerous experiments before I came upon this apparently simple solution to get him to eat his food. In that moment, I thought I was experiencing a dawning and profound recognition of what it meant to be a mother. It was that, in part, but it was also a foreshadowing of the intense and unabated demands that would grow out of trying to understand and care for this little boy who was just a little different from everyone else and who needed responses that were also just a little different. This is why I believe it is important for clinicians to reflect on how they might need to therapeutically respond a little differently in their work with these clients.

My motivation also springs from my clinical practice work, a primary therapeutic focus of which is to offer integrative psychotherapy to adults with 'ADHD'. I continue to facilitate a monthly adult 'ADHD' group for the NHS Berkshire Trust that began in 2014.

Narrative beginnings

In the late 1980s and early 90s much of the research on 'ADHD' was coming out of the US. The 'disorder' of 'ADHD' and its treatment – usually with the stimulant methylphenidate (more commonly known as Ritalin) – were controversial. 'ADHD' was seen paradoxically as both a 'trendy' as well as a stigmatizing 'disorder' for a child to be diagnosed with. It is now well documented that children who are considered 'different' are often the object of bullying or ostracization by peers (Carlson et al., 2009, Dell and O'Neil, 2010), experience more conflict within the family (Wehmeier et al., 2010) and have greater difficulties in adaptive functioning in educational, community and other social settings (Wehmeier et al., 2010).

Indeed, as my son grew and went through his primary and secondary education, I saw how he would be bullied at school for being a peacemaker among football-playing-and-worshipping boys or carry a heavy book-filled backpack from classroom to classroom as his

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solution for not being able to organize or execute the act of differentiating which book to bring to which class. My dilemma, one many mothers face, was how to protect him, while at the same time giving him the space to learn and fail and succeed as his own person.

Being responsive to the context

This study is intended to explore the narratives of those children, now grown up, to explore the meanings they give to 'ADHD' 'through their stories that connect events over time and that offer an unfolding and developing picture of their lives.' (Dallos and Vetere, 2005: pp. 68-69).

In a recent research paper in the field of 'ADHD', the team, which included British researcher Professor Philip Asherson, noted that 'there is limited evidence of the unmet needs and experiences of adults with ADHD in the published scientific literature' (Matheson et al., 2013: p. 1). The purpose of this research project is to give a voice to the experience of some of those adults by listening to their stories, analysing their narratives and exploring the implications of their experiences for their counselling needs.

How is 'ADHD' currently defined?

The prevailing medical wisdom is that 'ADHD' is considered to be a neurodevelopmental disorder that is generally estimated to affect 9% of children (Centers for Disease Control and Prevention (CDC)) and 4.5% of adults (Kessler et al., 2007). The prevalence of male to female 'ADHD' diagnosed is cited as 6:1 in children and 1:1 in adults (CDC). 'ADHD' is supposed to prevail at all levels of IQ and socio-economic status and while environment is considered influential a parent diagnosed with 'ADHD' has a 57% chance of having a child who also has an 'ADHD' diagnosis (Biederman et al., 1995). While genetic determinants are considered to play a role in 'ADHD', premature birth, other obstetrical complications, maternal smoking during pregnancy, paediatric head trauma, and chaotic family environments in particular, are all thought to predispose to the later development of 'ADHD' (Hinshaw et al., 2000).

Is it all just in our 'medical model' heads?

Timimi (2009), a contrarian in the field, points out in his critique of the National Institute for Health and Care Excellence (NICE) guidelines on 'ADHD' (2008)[2], not only that the neurodevelopmental model of 'ADHD' is 'based more on ideology than science', but also that important questions such as 'differences in rates of diagnosis by ethnicity and the differing meanings attached to ADHD symptoms in different societies were not addressed' (p.6). Panksepp has produced some interesting research suggesting that, in part, attention deficit and hyperactivity 'disorder' is not so much a disease as a strategy for learning via increased play - that it seems the disorder could stem from strictures on activity in present-day educational settings (Panksepp, 2001).

The criteria for the 'disorder'

Core symptoms are considered to be pervasive inattention, hyperactivity and impulsivity. According to both the Diagnostic and Statistical Manual of Mental Disorders (DSM-5: APA, 2013) and the International Classification of Diseases (ICD-10: WHO, 1992), for a valid diagnosis of the 'disorder' symptoms must have manifested prior to age 12 and 7 respectively – therefore, from a medical perspective, an 'ADHD' diagnosis can only be valid if identified in childhood. Associated symptoms must cause significant impairment socially, academically, or occupationally in a least two or more settings such as school, work and home. However, it must be noted that hyperactivity, impulsivity and short concentration spans are common behaviours, particularly among boys. As Timimi points out: 'Who should and how should we decide where the cut off between normal and pathological lies?' (2009: p.140).

Currently, when it comes to considering adults, there is some, but not much, differentiation from childhood descriptions. Up until 2013 when the DSM was revised in the

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[2] The NICE guideline for ADHD diagnosis and management was made available online in September 2008; it was revised in March 2018. (https://www.nice.org.uk/guidance/NG87)

5th edition, the criteria had never been validated in adults, did not include developmentally appropriate symptoms and thresholds for adults, failed to identify significantly impaired adults who were likely to benefit from treatment and there was insufficient data to justify use of assessment measures, including neuropsychological tests and brain imaging (McGough and Barkley, 2004). In the DSM-5 the only significant changes in how the condition is characterised in older adolescents and adults is the addition of some example behaviours intended to better define some of their symptoms. Some deference is paid in the DSM-5 to an increased acceptance that the condition is a dimensional disorder, in other words, behavioural traits that naturally occur on a continuum include supposed symptoms of 'ADHD' such as inattention, hyperactivity and impulsivity (Epstein and Loren, 2013)

The 'disorder' is usually broken down into three types: Predominantly Inattentive, Predominantly Hyperactive-Impulsive, and Combined Type. There is, however, 'little guidance and few examples for the adult assessment of 'ADHD'" (Asherson et al., 2010). Clinical, epidemiological, and family-genetic studies seem to provide evidence that a diagnosis of 'ADHD' is a strong predictor of conduct disorder, depression, anxiety disorders, and substance abuse both in temporal cross section and in later life (McArdle et al., 1995) (Peterson et al., 2001).

The hit and miss of standard treatment

Guidelines for the treatment of adult 'ADHD' (In UK, NICE, 2008; in US, NIMH) cite medication as the first line treatment for 'ADHD'. NICE sceptics point out that its recommendation is based on three studies with a duration of 21-45 days (Moncrieff and Timimi, 2013). Stimulants such as methylphenidate, and non-stimulants such as atomoxetine, are heavily relied on to address symptoms associated with focus deficits and inattention (Asherson, 2005).

The problem with conceptualizing 'ADHD' as a biological condition is that 'biological treatments, particularly the use of stimulants, have become the dominant and often only

treatment provided for those diagnosed' (Timimi, 2009: p. 5). In a growing body of research other options cited support skills-based individual and group psychosocial treatments, with a heavy application of cognitive-behavioural approaches (Rowland et al., 2002, Philipsen et al., 2007, Knouse et al., 2008), as well as coaching to modify behaviours. An additional treatment option is the learning of problem-solving skills for identified practical problems (Asherson, 2005).

My experience with my son was to initially resist treating his symptoms with stimulant medication when he was diagnosed at 7, as I was suspicious of possibly unknown long-term side-effects. I am, after all, a child of the thalidomide generation in which insufficiently tested medication designed as a safe sleep aid and used to alleviate morning sickness in pregnant mothers resulted in babies being born with severe birth defects. However when my son was 11, the pain of his impairment around social and peer groups at school made me resort in desperation to allowing him to be prescribed Ritalin. His experience of taking medication was relief that he was able to 'think a thought all the way through' for a change. He was no longer on the other end of a chaotic soup of thoughts that propelled him, like some surreal neurological bumper-car experience, from one random thought assault to the next. He finally had some agency in his actions as he responded to the messages his brain was sending him. The object lesson however, was that, while this helped his internal management of his own thinking, medication did not have much direct application to how he felt about himself or how he could improve his interpersonal relationships with peers, teachers and family members. The truism, that I first heard at an international conference on 'ADHD' is: 'Pills don't build skills'.

The pathologisation of 'ADHD'

While I accept that 'ADHD' is classified as a diagnosis, what I find more useful as a psychotherapist in my work with clients is to think of it as a different kind of self-state. Bromberg talks about how when a child suffers consistent non-recognition and disconfirmation of their self-experience, the consequence can be a developmentally

traumatic internal tsunami. I believe that the experience of 'ADHD' – being on the other end of your brain sending you signals that your intellect confirms are unreliable and which result in mis-attuned behaviours and relationships in the world – is another kind of tsunami.

> 'Whenever a developmental tsunami has hit, if left unhealed it has left a shadow. One lives with the shadow and, to one degree or another, it follows the person along the path to adulthood. Sometimes it accompanies the person throughout life, held as a part of a dissociative mental structure. The price paid for the protection afforded by a dissociative mental structure – the brain's proactive effort to foreclose the potential return of affect dysregulation associated with the residue of the relationally unprocessed trauma – is huge.' (Bromberg, 2011: p. 5)

The developmental tsunami goes hand in hand with the 'ADHD' tsunami, and each compounds the effects of the other in quite pernicious ways. I indicate my stance (see footnote, p.7) on the stigmatising effect that clustering a group of behavioural identifiers and calling them deficits and disordered has. Names do hurt us. In addition to the inverted commas placed around the term 'ADHD' I also use 'with ADHD' where possible in service of this principle. It must suffice until some consensus from those who experience the condition guide us to a more accurate, less diminishing, description of what their experience is.

But how does it feel?

As a psychotherapist, what is in short supply from much of the considerable body of extant research are studies on how this condition affects the development and perception of an individual's sense of self. In many respects, the impact of 'ADHD' has echoes of the impact of trauma on the individual, including the propensity to blame the victim (Herman, 1992). Some view early trauma as a contributing agent to a later diagnosis of the condition (Sugarman, 2006). Others see it as a behavioural, emotional and cognitive condition that indicates an underlying disturbance in the synthetic, organising, and integrative functions of

the ego (Gilmore, 2000).

Individuals with 'ADHD' can function extraordinarily well in the world. There are constant reminders of success stories such as Simone Biles, the American Olympic winning gymnast, British comedian Rory Bremner, Sir Richard Branson, the English founder of the Virgin group of businesses, actors Jim Carrey and Ryan Gosling and singers Justin Bieber and Justin Timberlake. But their 'poster child' image often masks what Bremner has called the 'hell' of living with the condition, acknowledging frankly that it 'can make you hate yourself' (Hawksley, 2017).

Many individuals with 'ADHD' report experiencing positive effects from the divergent thinking that emerges from the disinhibitory effects of a differently wired executive control neural network. Divergent thinking is the ability to generate multiple ideas or solutions to a problem. It is suggested that there may be a positive relationship between poor inhibitory control and divergent thinking which represents an advantage to adults with 'ADHD' (White and Shah, 2006). Another study suggested that 'ADHD' individuals report greater lifetime creative achievement compared to non-'ADHD' adults as well as differences in creative style (White and Shah, 2011).

Research Aims

While there is a steady rise in the number of qualitative studies taking adults diagnosed with 'ADHD' as their subject, much research to date has been quantitative and heavily influenced by the medical, neurodevelopmental model of discourse; there remains a lack of diverse qualitative inquiry, a lack which is only now beginning to shift. Sarrami Foroushani points out that in the medical model of ADHD, it is implicitly assumed that health care professionals produce knowledge via research and then apply it to 'passive' patients (2009). This view tends to an objectification of the individual and may further contribute to the dis-empowerment of some 'ADHD'-diagnosed adults.

Critics such as Moncrieff and Timimi (2011) fundamentally question whether adult

'ADHD' is a legitimate medical disorder. They suggest that it may be better understood as 'representing the medicalization of various common difficulties driven, among other factors, by the interests of the pharmaceutical industry and the reinforcing effects of stimulants' (p. 337). Indeed 'ADHD' is not easily distinguished from 'normality', there is a large overlap with other conditions, drug treatments do not easily demonstrate either efficacy or utility, and outcome is heterogenous (p. 337).

So, what are we to make of all these contradictions? In a meta-analysis of global prevalence in the general population, researchers estimated adult 'ADHD' occurs at a rate of approximately 4% worldwide (Brod et al., 2012). Even if we conservatively estimate a 1% rate of occurrence, this means that, for example, in the greater London population of 8.7 million (Review, 2018), there is a potential for at least 87,000 individuals to be affected by the condition. These voices are clearly not being heard. This study wishes to set to one side the polemics around 'ADHD' and engage in an open exploration of the stories of adults who themselves identify with it.

Kim Etherington, a seminal contributor to the qualitative methodology of narrative inquiry, has said that 'Telling our story is a way of reclaiming ourselves, our history and our experiences; a way of finding our voice' (2000: p. 18). She identifies the empowerment that comes from having a voice, citing McLeod who affirmed: 'Being powerful requires the willingness of other people to listen, hear, to be influenced by what that voice has to say' (1997: p. 93). A further aim of this research is therefore to apply the knowledge garnered from these narratives to influence the practice of counselling psychology and respond with greater precision to the counselling needs of the 'ADHD'-identifying client.

In considering the experience and counselling needs of adults with 'ADHD', I was interested in using the interpretative methodology of narrative analysis to consider their stories which 'provide rich data that express movement, interpret ideas, and describe from the storyteller's perspective how things used to be, and how they are, as well as how they should be' (Feldman et al., 2004: p. 150). In this way, I hoped to keep the focus on each adult

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with 'ADHD' as a 'self-aware agent striving to achieve meaning, control and fulfilment in life' (McLeod, 2011: p. 117).

Literature Review

The history and current understanding of adult 'ADHD'

As with many other psychiatric disorders there is no biological test for the presence of 'ADHD' and diagnosis has always been heterogeneous and behaviourally based. As early as 1902 it was described in children as an 'abnormal defect of moral control' (Still). Since then it has been severally known as minimal brain damage syndrome, minimal brain dysfunction, hyperkinetic reaction of childhood, and attention deficit disorder (Rowland et al., 2002). By contrast, Dr. Baughman, a vocal critic of the purely medical model view of 'ADHD', goes so far as to suggest that 'if no physical examination, lab test, X-ray, scan or biopsy shows an abnormality in your children, [your child is] normal' (1998) and this view can be extrapolated to include adults.

The first research that identified 'ADHD' as an adult 'disorder' was written in 1976 (Wood et al.), but the assumption up until the mid-to-late 90s was that it was a condition that tended to improve with age, having little or no impact into adulthood (Hill and Schoener, 1996). One positive development of the classification of 'ADHD' in the DSM and ICD was to allow it to move from a 'moral view of laziness into a neuropsychologically informed understanding of executive function and inhibition' (Young and Bramham, 2007: p. xvii). Even now, general adult psychiatry has yet to recognize the persistent impact that symptoms attributed to 'ADHD' have on adult psychopathology (Asherson, 2005). While one consensus statement (Kooij et al., 2010) suggests that in the majority of cases 'ADHD' persists into adult life where it is associated with a wide range of clinical and psychosocial impairments, there are other empirical studies which support a more optimistic perception of outcome in adulthood (NICE Guideline Stakeholder Comments, 2008).

It is also true that many high-functioning adults diagnosed with 'ADHD' have the capacity for excellent adaptation of their symptomology. Gerber, a pioneer in the study of high achievement among adults who have learning disabilities, has written that 'there is a

developing literature on those with L(earning) D(isabilities) and/or ADHD who have exhibited almost incredible resilience throughout their lives to overcome major hurdles to adjustment, finding avenues to notable achievement' (Gerber, 2001: p.1).

Looking to a non-medical/scientific source – the internet – for a prevailing understanding of 'ADHD', Foroushani (2009) investigated the availability of different views of 'ADHD'. She found that the majority of web pages she looked at agreed with themes described in the medical model. She reported that around 90% of the 30-50 pages she looked at confirmed the existence of 'ADHD' and of it being a medical 'disorder'. More than half of the pages agreed with the use of stimulant drugs for treating 'ADHD' and a fifth of web pages reported disagreements. The main objections to the medical model of 'ADHD' was the use of drugs, followed by the labelling of patients. While it appeared that there was some variation in the current view of 'ADHD' as a valid diagnosis, this study concluded that from this source, the dominant voice is that of the medical model.

The media is increasingly playing a part in shaping the prevailing cultural constructions of 'ADHD'. One French study showed that, in the years between 1995-2015, two models of 'ADHD' coexisted: the biomedical and the psychosocial. While French newspapers understood 'ADHD' to be a real condition requiring medication in addition to other psychological approaches, it was not seen as a neurological disease to be treated with a drug. However French TV described 'ADHD' as an inherited neurological disease, with medication presented as something that would aid in preventing school failure (Ponnou and Gonon, 2017). This study illustrates the common media focus on child, as opposed to adult, 'ADHD'.

The British Psychological Society (BPS) in its response to the NICE guidelines on 'ADHD', took exception to the diagnostic validity of 'ADHD' in adults, citing, among others, the fact that the suggested features of adult 'ADHD' 'include numerous aspects of mental functioning and behaviour that are not even examined in children, including lability of mood, stress intolerance, anger and risk taking' (2011, p. 4) . One of the most commonly used adult

assessment scales, The Conners' Adult 'ADHD' Rating Scales (CAARS), includes whole new domains such as 'problems with self concept' (Conners et al., 1999). I find it troubling that there is still no agreement about what level of symptoms can be expected as a baseline in either children or adults without the 'disorder'. The NHS criteria for an adult 'ADHD' diagnosis are also troubling in that their suggested list includes 'carelessness and lack of attention to detail', 'often interrupting others', 'inability to deal with stress' and 'extreme impatience'. These experiences and behaviours are pretty universal and definitely not unique to adults diagnosed with 'ADHD'. With such heterogeneity in diagnosis, it seems even more critical to listen attentively to the individual narratives of adult diagnosed with 'ADHD' for clues to understand their felt experiences and to let their voice prevail.

Under-reporting of adult 'ADHD'

The prevalence of 'ADHD' in adulthood suggests that it is under-reported by clinicians and this may very likely be caused by the often accompanying conditions with which the 'disorder' is often confused (Young, 2001). While new investigations continue into many aspects of adult 'ADHD', the volume of literature lags behind that of other adult disorders, and particularly that of 'ADHD' treatment in children (Knouse et al., 2008). In addition since 'ADHD' has only relatively recently been acknowledged in Europe there are many adults today who were never diagnosed or treated when they were children (McCarthy et al., 2009).

The NICE guidelines (2018) suggest two care pathways for 'ADHD' in adults: the first for those with suspected 'ADHD' and the second for those previously diagnosed with 'ADHD' in childhood with symptoms suggestive of continuing 'ADHD'. However, medications prescribed routinely for children diagnosed with 'ADHD' remain unlicensed for treatment in the UK for adults.

Subjective reporting of 'ADHD'

One qualitative study attempting to validate late-diagnosis individual perspectives noted

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that subjective descriptions focused on the mainly positive, but nuanced, impact of diagnosis on self-identity and experience of life (Hansson Halleröd et al., 2015). While identifying with 'ADHD' could provide retrospective explanatory and relieving self-knowledge, it also caused a devaluation of the self because of feelings of being less capable. Some destabilization of a sense of self was experienced for individuals who now questioned which part of their felt identity belonged to them and which to the 'ADHD'. While I appreciated the efforts of these researchers to validate 'ADHD' from the individual perspective, the 21 adults interviewed were screened out from others who were considered to have more severe comorbidities possibly having the effect of 'sanitising' the complexities of the condition's impact.

Adults usually find they have to reframe their past in the light of their new understanding of themselves once they have been diagnosed. There is emotional effort in realigning their internal vision of present self with their future expectations (Young et al., 2008). My clinical experience however is that the legacy of the powerlessness they feel over their actions, despite the sense that this has little to do with their capability, results in a severe fracturing and disintegration of self. What is felt to be particularly detrimental is the inability to control thoughts, emotions and behaviours; the lack of understanding of their social environment; and the combination of high self-expectation and poor self-image (Schrevel et al., 2016). The individuals in Schrevel et al's study also experienced themselves as gifted in being associative, creative and sometimes faster thinkers. The greater difficulty was not how they dealt with their symptoms as much as it was to cope with the misperceptions by others of themselves in social and personal environments (2016).

In addition to the need for an individual to be able to make sense of themselves, something a diagnosis of 'ADHD' often brings, there is also a need to feel that they have a place in their environment, that they can interact with others, belong in the community and be accepted by family and friends (Ghosh et al., 2016). Often substance misuse plays a part in an individual's choices because it allows them to feel and act more in keeping with the social expectations they feel are demanded (Nehlin et al., 2015).

The consequential or comorbidity risks in adulthood

The reality of living with the symptoms commonly associated with 'ADHD' over time is that its impairment goes far beyond the inattention, hyperactivity, and impulsivity that are said to characterize the core 'disorder'. One study goes so far as to state that 'co-morbidity could be considered the rule rather than the exception when 'ADHD' persists into adulthood' (Nutt et al., 2007: p. 25). Research shows that there is a high prevalence of co-morbid conditions such as learning disability and conduct disorder (Rowland et al., 2002). Adults with 'ADHD' are also susceptible to mood disorders such as anxiety and depression (Asherson, 2005) as well as to substance misuse (Adler et al., 2008). If one keeps an epigenetic framework in mind, could it be that the debilitating effects on the individual diagnosed with 'ADHD' of constant and continuous perceived failures on all fronts - familial, social, academic and relational – might be what leads to the almost ubiquitous diagnosis of low self-esteem in adulthood? (Young, 2001, Young et al., 2008).

A concurrent theme running alongside what might be characterised as establishment research is an underlying concern that 'normal' behaviour may be being partially pathologized in 'ADHD'. Deficits of attention are not uncommon on the mental health spectrum. Poor concentration is often a factor in anxiety disorders, and forgetfulness and inattentiveness can be a hallmark of depression. The hyperactivity in adult 'ADHD' can often look like hypomania. Individuals withdrawing from substance misuse may be restless, distractible or inattentive. Unstable relationships, impaired occupational histories and focus issues often attend borderline personality disorder presentations (Young, 2001). Part of the reasons for this may very well be indicated in a recent study from The Brainstorm Consortium (Anttila et al., 2018) indicating that there is a common variant risk for psychiatric disorders which correlate significantly among 'ADHD', bipolar disorder, major depressive disorder (MDD) and schizophrenia whereas neurological disorders are more distinct from one another and from psychiatric disorders, except for migraine which is significantly correlated to 'ADHD', MDD and Tourette syndrome. The conclusion from this work is that

current clinical boundaries do not reflect distinct underlying pathogenic processes, at least on the genetic level (Anttila et al., 2018).

An intriguing recent study (Thibault et al., 2018), albeit of only 9 children diagnosed with 'ADHD', in which positive verbal suggestions were given to promote relaxation, focus and confidence while the children were in a non-functioning magnetic resonance imaging scanner. Two families at the final follow up after six weeks reported near complete remission of symptoms and six reported improvements in confidence, self-control and social skills. On first reading I felt this study was about 'brainwashing' the children into believing they did not have 'ADHD'. Yet in my own clinical work I sometimes find myself working with a client to find ways together to 'trick' (in the sense of using a quick or artful way to get a result) their brains into managing some behavioural aspects of their 'ADHD'. If they can focus in one context, how can we work together to help them focus in another? While the study does not assume cause and effect, it does offer hope that there may be empowering value in harnessing individuals' subjective perceptions to positively manage some of the impairing elements of the condition by means other than medication.

While having 'ADHD' greatly elevates the risk for substance misuse, it may actually be considered a form of 'self-medication' as clinical observations also indicate that individuals presenting with a diagnosis of 'ADHD' with substance abuse disorder demonstrate an improvement in symptoms attributed to 'ADHD' (Magon and Müller, 2012). Nevertheless a diagnosis of substance misuse can in some cases lead to the refusal of treatment which serves only to further complicate an individual's 'ADHD' experience.

Adult 'ADHD' – the challenge of later life diagnosis

All the individuals in my study were not diagnosed until they were in their adulthood. The NHS website on 'ADHD' suggests that it is believed that it cannot develop in adults without it first appearing during childhood, yet it is known that symptoms of 'ADHD' often persist from childhood into adolescence and then into adulthood. Because for a long time 'ADHD'

had been considered a childhood-onset neurodevelopmental 'disorder' there was little or no acknowledgement, understanding or support for adults. This means that these adults had been affected by, had to adapt to, and make what sense they could of their experience of the condition for perhaps many decades.

The neurobiology of 'ADHD'

Research findings on 'ADHD' neuropathology seem to indicate that it is not rooted in a single anatomical area, but in multiple parallel and intersecting pathways, which have demonstrated impaired functional connectivity in 'ADHD' brains (Alexander and Farrelly, 2017). This may account for dysfunctions in executive function, reward processing, attention and default mode networks. There is a strong argument that individuals with these kinds of impairments become neurobiologically adaptive to cope with and work around their deficits. Indeed, adults with 'ADHD' may recruit novel neural pathways while organising less efficient strategies to solve working memory tasks, thereby using compensatory mental and neural strategies in response to their disrupted ability to inhibit attention to non-relevant stimuli (Schweitzer et al., 2000).

The neurobiology of the self

There is evidence that the right hemisphere of the brain is dominant for a sense of self and is implicated in the relation of self to the social environment. This includes being able to withhold thoughts or answers and using internal and external cues to modulate conversation as well as having a capacity to monitor the impact of comments on listeners (Devinsky, 2000). The common impulsive blurting out of the person with 'ADHD' shows some impairment in this domain.

The frontal lobes, which control attention, goal-directed behaviour and inhibit impulses are implicated in 'ADHD' (Schneider et al., 2006). Individuals with 'ADHD' often speak of having to contend with a brain that is in 'on' mode virtually all the time, thoughts teeming,

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jumping from one to another, an internal involuntary process over which he feels he has no control. If this internal state is coupled with flooding emotions the resultant sense of chaos may augment to a level of overwhelming trauma. When a self is in a state of intense, dysregulated sympathetic hyperarousal, it demands excessive energy expenditure that can lead to a temporary paralysis of the right brain core self's integrative function causing self-fragmentation (Pao, 1979). This fragmentation of the mind-body self can be felt as a threat to one's bodily wholeness and survival, the annihilation of one's core being, and thus represents 'the deepest anxiety man can experience' (Kohut, 1984: p. 16).

Relational trauma in 'ADHD'

Caregivers have spoken of their experience of raising 'ADHD' children as unrelenting, overwhelming, frustrating and difficult, draining them and contributing to feelings of dejection and anxiety (Peters and Jackson, 2009). These parents typically display high levels of over reactivity and tend to be more critical of their children, less rewarding, and less responsive than parents of children without ADHD. The degree of parental dysfunction appears to correlate with the presence and severity of 'ADHD'-related disruptive disorders such as Oppositional Defiance Disorder and Conduct Disorder. There is evidence to suggest that poor parental skills may exacerbate children's self-control deficits and contribute to the development of additional disruptive disorders that worsen ADHD outcomes (Modesto-Lowe et al., 2008). Not all adults with 'ADHD' come from dysfunctional families, but there is often a 'vicious spiral of interaction between the child and the family which gives rise to a malignant escalation of mutual distress and intense negative emotion' (Mollon, 2015: p. 26)

We worry traditionally about care-givers not attuning well to the child, but what if the child cannot attune to the care-giver? Research suggests that relational trauma causes physiological dysregulation, as well as structural defects of cortical-subcortical circuits of the right brain, the locus of the corporeal-emotional self (Schore, 2002). This seems to have an effect on the self's capacity for empathy and body awareness, and may account for the reduction in the ability to modulate and reduce the effects of 'shame, rage, excitement,

elation, disgust, panic-terror and hopeless despair' (Schore, 2002).

The development and structure of the self

Attachment theory stipulates that the emergence of the self requires the presence of others ((Bowlby, 1969). Caregivers who perform critical regulatory functions for an infant in the process of development are posited to provide that child with selfobject experiences which contribute to the vitalization and structural cohesion of the self (Schore, 2002). Selfobjects are considered to be objects which we experience as parts of our self; they are either those who respond to and confirm the child's innate sense of 'vigour, greatness and perfection' (Kohut and Wolf, 1978), or those to whom the child can look up to and merge with as an image of 'calm, infallibility and omnipotence' (Kohut and Wolf, 1978).

Similar to Bowlby and Ainsworth's attachment theory, Kohut believed that the development of a cohesive self depends on the availability and responsiveness of significant others, especially when a person seeks help with distress regulation (Kohut and Wolf, 1978). One of the functions of the right brain, dominant in infants and the first three years of life (Chiron et al., 1997), is to 'maintain a coherent, continuous, and unified sense of self' (Devinsky, 2000). An infant in a state of emotional dysregulation utilizes all its resources to return to a state of homoeostasis; there are thus no resources available for self-development and intersubjective communication. This process, Schore suggests, creates a void of subjectivity (2002). Self-object failures and defensive dissociative responses are likely to strain the capacity to maintain metabolic-energetic equilibrium and may result in what Mollon calls a disintegration of the self (2001).

One theory of what results is that unconsciously constructed organizing principles (Atwood and Stolorow, 2014) are constructed to make sense of what are jarring emotional experiences. These principles then become the scaffolding in the construction of a person's world that appears objectively real. Experiences of self and others would then be felt as products of reality rather than subjective interpretations and constructions (Atwood and

Stolorow, 1984).

An impaired capacity to attune in relationship is marked in the adult with 'ADHD'. She is often unable to pay attention in a conversation with another, missing details and others may feel ignored or boring. Her compromised memory means that she forgets what she has promised and leads others to feel she is unreliable, if not downright uncaring. Having emotional regulation difficulties means others cannot relax around her as she may be volatile or unable to discuss things calmly. Others feel they are doing all the work because she often cannot finish tasks (Jeavons et al., 2018). For the 'ADHD' adult, the relational experience can often be one of a lack of authorship or agency, leading to a sense that 'one is reactive rather than free to formulate intention, one feels to blame rather than responsible, one feels controlled rather than recognized' (Benjamin, 2014: p. 50). 'ADHD' is a hidden disability; it is not seen by an other, it is experienced emotionally and interpersonally; intention is misperceived, misinterpreted, misunderstood and, very often, taken personally.

Current thinking on the role of attachment in a consideration of 'ADHD'

According to Bowlby, the attachment system is a bio-behavioral system whose primary function is to promote an individuall's survival, using different strategies for coping with threat. These strategies centre around arousal regulation, the meeting of basic physical and emotional needs, and the intersubjective experience of eliciting and receiving emotional responses from and with others. Children with insecure or disorganised attachment configurations have negative experiences of their surroundings and will often be troubled by anxiety.

Though there is currently no clearly defined etiology for the 'disorder' of 'ADHD', evidence does seem to implicate a difficult-to-differentiate overlap between genetic, neurological and behavioural explanations and similar processes could result from environmental causes or from the interaction of genetic and environmental conditions (Halasz and Vance, 2002).

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With regard to attachment difficulties in the environment, research seems to indicate that a number of family characteristics such as marital discord, hostile parent-child relationships and discordant family life are all associated with ADHD (Crittenden and Kulbotton, 2007). In addition, children with disorganised attachment have significantly higher levels of 'ADHD' symptoms compared to those in the secure category. Both 'ADHD' symptoms and disorganised attachment are related to incoherence and negative content (Scholtens et al., 2014). Secure attachment, by contrast, is associated with cognitive impulse control, task orientation and delay of gratification at the age of 6 years (Olson et al., 1990).

While the link between attachment and 'ADHD' is still not demonstrated – and the debate between the influence on 'ADHD' of nature versus nurture continues, it could be argued, as Erdman does, that 'ADHD' behaviours are a contextual response to a parental attachment, displayed in order to maintain a specific parent-child relationship with the aim of keeping it organised (Erdman, 1998). It seems clear that the expression of 'ADHD' symptomology, either genetically or neurologically, would only be exacerbated negatively by a less than optimal developmental environment.

Possible connections between trauma, dissociative processes and 'ADHD'

A primary attachment figure has the power to destabilise mental state. This has the potential to rupture the sense of self-continuity (Bromberg, 2011). Trauma may occur when the individual is unable to regulate his mental state and restore emotional equilibrium (Mollon, 2001). The individual with 'ADHD' already has difficulty with emotionally calibrating themselves to their environment. As Littman points out: 'Physiological hypersensitivity causes the 'ADHD' brain to be reactive rather than proactive much of the time.' (2009: p. 1) The part of the self that has been refused recognition becomes dissociated, a 'not-me' (Bromberg, 2011). Trauma collapses meaning and leaves the individual vulnerable to intense and overwhelming anxieties from internal as well as external events.

The longer lasting effects of such intersubjective misattunements may lead to a

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dissociative emotional survival technique of disengaging from external stimuli in favour of attention to their internal world (Schore, 2002). This can include numbing, avoidance, compliance and restricted affect, all with the intent of becoming unseen (Schore, 2015). In adults, experiences of external or relational trauma can imbue the present with the significance and meaning of the past (Garland, 1998). The person with 'ADHD' too often has an internal familiarity with a sense of 'failure' that is not easy to shake when confronted by needs in the here and now to be on time, pay attention, complete tasks or follow through on a promise.

Dissociative processes may function as ways to try and separate the individual from the pain of psychic trauma. In order to protect the sense of coherence that is the self, internal processes may shatter self-organization (Dell and O'Neil, 2010). Experience seems to be processed largely in the nonverbal or preverbal domains of experience (van der Kolk, 1996). These processes may contribute to halting the formation of a personal and verbal narrative that connects experience with the self, thereby preventing affect, cognition and sensory information from being integrated (Dell and O'Neil, 2010). This may manifest in individuals as poor self-esteem, a sense of inner emptiness, a not-knowing who they are, and poor relational competence due to an inability to read interpersonal cues and a lack of access to inner emotional experience (Dell and O'Neil, 2010). In online narratives of adults who were diagnosed with 'ADHD' in adulthood, narrators experienced repeated failures in many aspects of life and had internalized negative views to which they had been subjected in their social environment (Fleischmann and Miller, 2013). The development of self-blame subsequently further hampered their functioning. Once diagnosed with 'ADHD' these adults were able to construct a more coherent view of their life and of their difficulties, move beyond guilt and understand that they could overcome their challenges (Fleischmann and Miller, 2013).

First-personal experience of adults with 'ADHD'

Despite the alleviation of some symptoms that medication may bring to many adults

diagnosed with 'ADHD', particularly concerning the classic inability to focus, medication may not fully address the multiple domains of impairment experienced by adults with this 'disorder' (Knouse et al., 2008). Indeed not all individuals respond well to medication. Approximately 20-50% of adults diagnosed with 'ADHD' are considered nonresponders due to insufficient symptom reduction or an inability to tolerate medication (Bramham et al., 2009). These adults often live with a chronic sense of being unable to meet the demands of daily life (Ramsay and Rostain, 2005). Many adults have memories from childhood and adolescence of being told they were stupid, lazy, and disruptive (Young and Bramham, 2007). As adults they typically have trouble wrapping up the details of projects once the challenging parts have been done; have difficulty getting things in order when organization is required; have problems remembering appointments and obligations; avoid or delay tasks that require a lot of thought; fidget or squirm with hands or feet when having to sit down for a long time; and feel overly active and compelled to do things as if driven by a motor (Adler et al., 2003).

Once diagnosed and treated with medication many 'ADHD' diagnosed adults follow what one study identified as a 6-stage model of psychological acceptance: 1) relief and elation, 2) confusion and emotional turmoil, 3) anger, 4) sadness and grief, 5) anxiety and 6) accommodation and acceptance (Young et al., 2008). Another study using interpretative phenomenological analysis found that increased awareness and acceptance of problems due to 'ADHD' allowed individuals to recognize and adopt greater personal responsibility for their self-generated behaviour (Young and Bramham, 2007). This study did not take into account the whole experience of the individuals in its effort to look only at the 'ADHD' component. The consequences of the dynamic interaction between the self, the relational and developmental early environment and the neurobiological therefore become invisible.

A Dutch study identified 5 personal discourses which structure adults' descriptions of their 'ADHD'. Seeing themselves as, on the one hand, 'slaves to their failing neurobiological systems', they also believed that knowing themselves was a way of turning the 'disorder' into

an advantage; that while it was the demands of present society which made the ever-present characteristics ascribed to 'ADHD' into a problem, they believed that the positive sides of diagnosed 'ADHD' 'bring color to the world' and stressed how important it was to be diagnosed, as this offered an explanation for the problems they faced and reduced their sense of shame (Bröer and Heerings, 2013).

Individuals who exhibit 'ADHD' behaviours are stigmatised and perceived negatively at all developmental stages (Lebowitz, 2016). In one unusual study - because it was done with 'ADHD' adults aged 50+ - researchers found that participants reported significantly reduced quality of life when compared with population norms indicating that the negative impact of 'ADHD' persists into late adulthood (Lensing et al., 2015).

The NICE guidelines recommended that all 'ADHD' diagnosed patients should have a comprehensive treatment program with pharmacological treatment offered unless patients preferred psychological treatment alone NICE (2008). However a 2013 qualitative study suggests that there is a wide gap between policy and current practice in England (Matheson et al.). Not only is getting a diagnosis and accessing services 'an uphill struggle' (Matheson et al., 2013: p.5), many adults also had difficulty coping with emotions which could become overwhelming. Many of the participants desired additional but unavailable psychological support. One person reported that while medication was effective for treating about 30% of the condition: '30% of the condition it doesn't deal with and the other 30% is actually the effect the condition has had on you all your life without knowing. ....There needs to be more work on counselling.' (Matheson et al., 2013: p. 8). This study points to something that is being critically undervalued when it comes to a consideration of any treatment for the condition – its impact on how an individual feels about themselves. How to address this concern clinically could arguably be as important a focus of treatment as the management or modification of behaviours.

Attending to 'ADHD' self states

There are very few studies which examine how adults diagnosed with 'ADHD' manage their 'ADHD' from their own perspective or indeed the meaning that these adults impart to their living with 'ADHD' in adulthood (Fleischmann and Miller, 2013). Additionally, recommended therapeutic interventions tend almost exclusively to assume that the nature of the 'disorder' demands the improvement of cognitions, behaviours and organization once a medication regime has been put into place. Little or no attention is devoted to identifying any specific emotional traumas attendant upon the 'disorder' which in many cases can be assumed to have contributed to, and perhaps even engendered, co-morbidity development.

Present study: The importance of narrative

Although 'formal' clinical mental health knowledge is produced via non-qualitative studies, narratives of patients (*i.e.* qualitative data) could also have a crucial role within the application of medical/psychiatric knowledge (Sarrami Foroushani, 2009). The recognition of adult 'ADHD' remains a rare specialist concern among psychiatrists (Asherson, 2005) and we can, by extension, fairly include psychologists, therapists and counsellors in that group. There is a need for a community of researchers focused on expanding treatment options for adults as well as providing further education on 'ADHD' ascribed symptoms to clients, clinicians, researchers and the public (Knouse et al., 2008). Most importantly Tatersall (2002) draws our attention to how clients are more than passive recipients of 'ADHD' knowledge or treatment:

> "Many patients are expert in managing their disease, and this could be used
> to encourage others to become 'key decision makers in the treatment process'.
> Furthermore, these expert patients could 'contribute their skills and insights for
> the further improvement of services' ... there should be 'a cultural change ... so
> that user-led self management can be fully valued and understood by healthcare
> professionals' (p.1).

This study therefore utilises the qualitative methodological approach of narrative inquiry as it's aim is to provide in-depth insight into individual's experiences. Greenhalgh and Hurwitz (1999) explain the importance of patients' narratives:

"Narratives of illness provide a framework for approaching a patient's problems holistically and may uncover diagnostic and therapeutic options" (p. 48).

In the final analysis, what I find meaningful about this methodology is the fact that at its core narrative inquiry is simply 'the study of the ways humans experience the world' (Connelly and Clandinin, 1990).

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Methodology

Philosophical framework

My initial exploration of the research literature on 'ADHD' pulled me inexorably towards the quantitative methodologies as much of it is produced by medical model professionals. It is a glorious thing to attend a World Federation of ADHD conference, to see thousands of scientists devoted to the work of understanding how 'ADHD' looks, what its possible causes are, and how to treat, mostly medically, the 'disorder'. I came away full of facts, figures and science, and admiration and awe for the professional dedication devoted to expanding and building upon the knowledge base. Yet I also felt removed from the lived experience of the individuals who dealt daily with the consequences of what it might feel like to be a round peg in a square world. My choice of methodology therefore leaned towards the qualitative methodologies as they take an interpretative position and conduct research aiming to understand culturally specific information about the values, opinions, behaviours, and social contexts of particular populations and describe how people construct meaning for themselves within and from these cultural contexts.

I understand the nature of human beings to be, above all, relational, and for whom meaning making is essential. We seek connection, attachment, relationship with others because loving and being loved is an essential and core characteristic of what it means to be human. The emergence of the postmodern view of reality holds that an individual does not exist in a vacuum but that personal stories are inevitably influenced by social, communal and linguistic constructions of that reality (Gergen, 2001).

Given that my Irish heritage is rich with the language of story and poetry and my own understanding of the world shaped by a study of literature, it seemed a natural consequence that narrative constructionism should exemplify my own epistemological stance. This approach 'conceptualises human beings as meaning-makers who use narratives to interpret, direct and communicate life and to configure and constitute their experience and their sense

of who they are' (Smith, 2016: p. 204).

At the same time, I feel a discomfort with a too exclusive focus on the analysis of language alone, as it may marginalise other experiences as objects for analysis (Sims-Schouten et al., 2007). As an integrative psychotherapist whose stance as a scientist-practitioner leans towards research on what needs to be changed, as well as asking questions on how change occurs, I also hold a critical realist stance. This perspective, while acknowledging multiple social, cultural and language-based constructions, maintains that there is a human reality that exists independent of social context (Bury and Strauss, 2006).

That I am not what some might call a 'pure' narrative inquirer was brought home to me in a discussion with Kim Etherington about what she saw as the essential principles to follow in using narrative inquiry methodology. The stance in this form of narrative inquiry emphasises the idea that reality is relative, interpreted through an individual's personal belief systems. It also privileges the co-creative act between researcher and participant which results in a documentation of meaning making, giving equal weight to both the content and the way in which both narrator and researcher influence that contribution. I recognised how my thinking diverged, particularly in the emphasis it places on how far researcher reflexivity goes. While meaning-making occurs in interaction, especially through language, other non-discursive elements can also be included to contribute to that meaning. Some examples of non-discursive elements germane to this work might be considered to be the possible embodied factor of 'ADHD' itself or the ability of medical and psychiatric institutions to define access to medication or the promotion of one treatment form over another. A critical realist approach can not only do what narrative inquiry does in extracting wider cultural narratives from participant stories but is also able to position participant talk within the materiality that they also have to negotiate. Both perspectives do allow for valuing the narrative knowing that Bruner talks about which helps makes sense of the ambiguity and complexity of human lives (Bruner, 1986).

I had learned to speak with my own voice during my integrative psychotherapy training,

but I wanted to be heard in this work primarily as a psychotherapist-researcher. I also wanted to be transparent about my role as the mother of someone with 'ADHD'. More critical to me was that the voices of the participants be firmly in the foreground. I chose not to focus solely on how the 'language and practices that we employ carry with them a cultural 'archaeology' of meaning' (McLeod and Balamoutsou, 2001). This meant that I wanted first of all to examine and analyse the words of each participant to extract from their language their many-layers or archeology of *self*-meaning and understandings of 'ADHD.' I also wanted to operate as a witness of participant stories with a view to assembling 'a set of procedures and sensitising constructs appropriate to the job in hand' (McLeod and Balamoutsou, 2001). Once participant accounts were explored the job at hand for me was to contribute to 'the construction of frameworks for practice' (McLeod and Balamoutsou, 2001) by creating a set of therapeutic guidelines for clinicians.

At heart therefore, my epistemological and ontological position straddles both the constructionist and realist positions, combining both the roles of human agency in constituting the social world and an understanding that people's actions will be influenced by personal and societal mechanisms that are independent of our thoughts and impressions (Bhaskar, 2010). The narrative psychological approach allows room for a social constructionist epistemology which seeks 'culturally useful theories and findings with significant cultural meaning' (Gergen, 2001: p. 808) along with a realist epistemology which studies personal, subjective and experiential forms of individual experience and 'positions their talk within the materiality that they also have to negotiate' (Sims-Schouten et al., 2007: p. 103) .

The methodology of narrative inquiry privileges individual stories and approaches the knowledge in those stories as constructed born out of the social and cultural worlds around us. Personal meaning is created in the situated contexts of time, geography, educational and political systems, as well as through inter-generational and familial relationships and traditions. However it is also possible that a too dominant storyline may suppress possible

alternative plots for the life. If individuals are caught between two social contexts that offer incompatible cultural narratives, for example, they may be unable to find an integrated personal narrative to tell (Adler and McAdams, 2007). Realist ideas can help us think about how socially constructed concepts such as stigmatisation promotes objectified and prescriptive realities which have a direct bearing on how we experience ourselves and tell our stories.

Stories help us to make sense of ourselves, they establish our identity. The life story model of identity emphasises the integrative nature of stories, how a given narrative has the power to bring together disparate features in a life and make unifying sense of them (McAdams, 2001). At the same time when a person tells stories there is always the possibility that they and their story can change over time (Smith, 2016) so an understanding of self is subject to change, modification and reinterpretation. Narrative constructionism therefore asks us to respect, as does counselling psychology, the personal subjective experience of the individual. The current research, therefore concerns itself more with narrative accounts of significant experiences rather than discursive structures of the stories and is thus a more explicitly realist endeavour.

Narrative inquiry

In keeping with the idea that stories change, I saw how my own story about my son's 'ADHD' had evolved over time. All my 'ADHD' stories capture something essential about my experience in the here and now; yet historically all of them were pieces of the complex 'truths' that were my experiences over time. Today I may gloss over the difficult visits to neighbourhood mothers to ask them to ask their sons not to pelt my son with chestnuts when they disembarked from the school bus at the end of the school day. Now that experience is summarised in the story that 'my son was bullied as a child because of his differences'.

Stories are specific tales that people tell (Smith, 2016). But to extract knowledge from

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them they cannot stand alone but must be linked to some theoretical context or previous knowledge (Lieblich and Josselson, 1997). Narratives take stories to a conceptual level by 'using insight and parsimony, where a different level of interpretation allows us to see things or organize data or to generalise...to other people or other aspects of experience' (Lieblich and Josselson, 1997: p. xii).

My psychotherapist-researcher self wanted to explore the participant narratives for the meanings of their stories in their here and now, knowing full well that there was sure to be a vast amount of unspoken or unremembered detail that informed each story. It was important to approach participants' narrative accounts from an empathic interpretative stance that prioritised the meanings that participants had constructed themselves (Willig, 2012).

What I value about the study of narrative is that it is 'the study of the ways humans experience the world' (Connelly and Clandinin, 1990). Narrative identity reconstructs the autobiographical past and imagines the future in such a way as to provide a person's life with some degree of unity, purpose and meaning (McAdams and McLean, 2013). The adults in this study spent much of their lives not being able to make enough sense of their way of being in the world. The reality of 'ADHD' is that it is not visible, it is a 'hidden disability', especially for those who do not come to understanding themselves through this informational prism until adulthood. It is also hidden because not easily discerned by others.

In listening and analysing the stories of the participants, I was mindful of a model of self-knowledge that resonates for me in understanding and complementing how we and adults with 'ADHD' can know and make sense of ourselves – the Johari window[3]:

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[3] The Johari Window was created by psychologists Joseph Luft and Harrington Ingham in 1955. 'Johari' combines their first names, Joe and Harrington. It was designed to help people better understand their relationship with themselves and others.

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The Johari Window – How We Know Ourselves

Known to self	Not known to self
Public Self Known to others	Blind Self Known to others
Private Self Not known to others	Unknown Self Not known to others
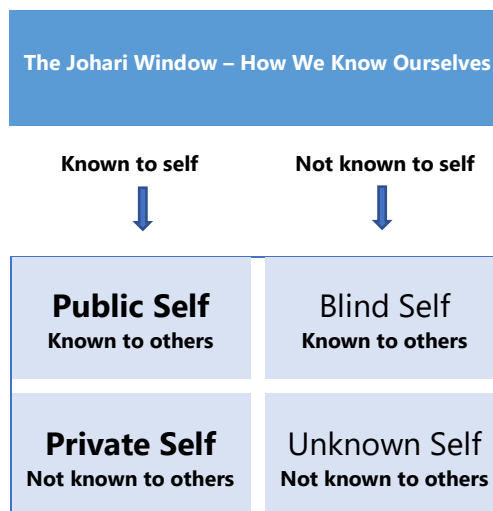
Because there are parts of ourselves that we are blind to, or are unknown to us, the stories participants tell are not to be misconstrued as mirrored reflections of experience, as people do not have complete access to their experiences (Polkinghorne, 2005). But client stories, what Freud called self-reflection reports, have been the primary manner of gaining an understanding of human experience in clinical and counselling psychology since his time. Using a narrative perspective allowed me to keep the integrity of the individual voices intact, while also privileging an understanding and enrichment of the experience of what it means to be an adult identifying with 'ADHD'.

Research design

I was initially concerned primarily about two things around how the interviewing process would take place. Firstly, mindful of how difficult it can be for someone experiencing the symptoms of 'ADHD' to sit still for long periods of time, I wanted the opportunity to be responsive to each individual's tolerance levels by having three separate interviews of approximately one hour each.

My experience as a therapist was that often someone will either try to say everything in a first session or needs time to warm to the ambiance of the relationship. The narrative

interview, in addition to describing what happened to the interviewee, also 'expresses emotions, thoughts and interpretations' and 'shapes, constructs and performs the self, experience and reality' (Chase, 2007). There was a potential for a lot to be going on. I loosely followed Seidman (2013) to aid me in this, focusing in the first interview on developing a rapport as we began to go through the initial interview questions, then using the second and third interviews to allow for exploring their experiences in more depth, and for them and I to fill in and clarify their accounts. Of interest to me was the presence of any repetition of events in the third interview and I contemplated possible explanations for this which could have included that the participant had reached some sort of saturation point in the telling of their stories. Another explanation could have been that the stimulation value of doing the interviews with me was beginning to wear off and the participant was under-stimulated enough to be becoming distracted and repetitious as a result.

Story analysis

In terms of analysis methodology, I loosely followed the preliminary analysis steps in Phase 1 of McLeod and Balamoutsou's procedures: tape transcription, reading and immersion in text, identification of stories, summarising stories and sequences and constructing a representation of the interview as a whole (2001).

Participants were encouraged to tell their stories in their own ways, so interview questions were of necessity broad and non-specific (see Appendix 3). Dallos & Vetere point out that 'the order in which people present the events in their life is important because it can reveal that apparently relatively minor events can hold significance for them and that their story may not be chronologically ordered' and emphasizes the importance of 'how participants frame their lives or tell their stories with reference to common, culturally shared ideas about what changes and key events are expected to be made in life' (2005: p. 69).

Participants

Given that 'ADHD' is, like most mental health conditions, diagnosed predominantly on the basis of behaviours, additional attention being given to school and interpersonal histories, it was important to me that those individuals who decided to participate in this study felt comfortable with identifying themselves as experiencing 'ADHD'. The irony was that of the six individuals who did participate, five had diagnosed themselves and had had to push, in some cases pretty vigourously, to get sometimes reluctant medical clinicians to refer them on for a formal diagnosis so they could access treatment. The sixth came to the realisation that she was very likely the 'ADHD' parent when her son was diagnosed as a child and the clinician who diagnosed him suggested that her experiences might also be representative of having the condition.

Without exception, all six participants identified immediately with the behavioural markers of the condition, had sounded it out with friends and family, and concluded that the descriptions commonly associated with a diagnosis of 'ADHD' made sense to and of them as individuals. In one case one participant's self-diagnosis was received by her GP with such scepticism that she was intimidated enough to give up pursuing it as she was afraid to jeopardise the otherwise supportive relationship she had with him. His narrative for her was that she was just experiencing depression and would likely need to be on anti-depressants and anti-anxiety as well as sleep medications for the rest of her life. This denial of her reality seemed to serve only to increase her already florid propensity for anxiety and depression.

Recruitment of participants

Participants were recruited via an email (Appendix 1) sent to a variety of organisations. In the case of an organisation such as a Learning Online website (now defunct), an offshoot of the Adult 'ADHD' Service run by a hospita, the moderator was asked to post the information sheet explaining what the research project was about online and its members were emailed about this as well as being able to access the request for participants on the site. I also asked

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a local Adult ADHD Service to post the information sheet attached to the email request on its notice board. I contacted a private 'ADHD' Clinic in the area and grass roots adult self-help groups for 'ADHD' that I was familiar with regionally seeking participants. Eight people responded to the recruitment notice. One disqualified himself as he felt he lived too far away. One did not meet the criteria as it was her partner who had been diagnosed with 'ADHD'. Those that did participate came from the Adult 'ADHD' group (5) and one from the Learning Online group. None of the participants from the Adult 'ADHD' group knew each other or about each other's participation in this study. This was happenstance really. The facilitator knew all the participants but as they did not attend the same meetings regularly, their paths had not crossed.

The age of the participants ranged from early 30s to early 60s (see Table 1 below). Two were women and 4 were men. Both women were working, one part-time and one full-time. One of the men was a retired computer programmer but volunteered as a docent at an art gallery. Two other men were self-employed as entrepreneurs. The youngest participant (30) was a political analyst. As receiving a formal diagnosis of 'ADHD' was highly meaningful and deeply affecting for almost all the participants, the age at which this occurred is noted in the table. All other personal details are deliberately kept vague to protect participant anonymity.

Table 1.

Name	Sex	Age	Occupation	Age Diagnosed	Medication	Diagnosis
Harry	Male	30	Political Analyst	29	Effective	Self/GP
Joe	Male	48	Entrepreneur	45	Partially effective	Self/GP
Edward	Male	61	Unemployed/Entrepreneur	60	Not effective	Self/Others
Sarah	Female	54	Part-time Teacher	50	Effective but blood pressure risk	Children/Self/GP
Heidi	Female	48	Nurse Director	42	Effective	Children/Others/GP
Huw	Male	58	Retired/Volunteer	54	Effective	Self/GP

Each participant was asked to meet for three separate interviews as I also wanted the experience to have something of the flavour of a relationship about it. I liked the view of the overlap between the skills needed in research interviewing and counselling psychology, and the shared importance of the ability to form an accepting relationship, skill in active listening, and focus on the other's experiential world (Polkinghorne, 2005). Interviewing six participants allowed for the eventuality that one or more participants might choose to withdraw, as happened with one of the female participants who ended the process after the first interview.

Collecting the narratives

Having initially received an email response expressing each participant's willingness to become part of the study, I followed up with a telephone conversation so that I could answer any questions, outline how I expected the process to go, and begin to establish a rapport

with each person. As a relational psychotherapist it felt appropriate to do this to put participants at ease. As a researcher it felt important to build sufficient trust and rapport with the participants so that one is assured that the participants are telling the truth as they know it (Morrow, 2005: p. 256),

Logistics as to where and when interviews might take place were also discussed on the initial call. To facilitate participants feeling comfortable, I agreed to meet in a variety of settings, aiming for either neutrality: an 'ADHD' clinic (1 participant) or the institute where I see psychotherapy clients (1 participant); or familiarity: their workplace (2 participants); and in their home (2 participants). One participant did the two first interviews with me in her home and the third at her workplace. All interviews were conducted face-to-face and digitally recorded.

Though I had emailed copies of the information sheet and consent form to each individual in response to their initial email saying they would like to participate, I brought another set along to the first interview, mindful of the capacity for someone with 'ADHD' to lose or forget things. The aim was to avoid any implicit shame or embarrassment on the part of the participant if they did indeed forget the paperwork as well as to ensure that the consent form was available to be signed. Two participants needed the copies I brought with me.

'ADHD' diagnosed adults often find it difficult to sit still for long periods of time because of an internal and highly intolerable sensation of boredom. Participants were thus asked at the beginning of each interview to let me know if they needed a break, or if they needed to stop the interview process entirely. As each of the three interview times were staggered over weeks, sometimes months, the novelty factor assisted in this process, and only one participant verbalized her sense of feeling fatigue and difficulty in keeping focused at the very end of the last interview. Interestingly this interview was done at the client's workplace which normally involved a great deal of responsibility and constant physical movement. It felt as if it was hard for her to switch roles from director to interviewee, and that the pull of

the context we were in made it very difficult for her to sustain a focus on our interview as a result.

Before starting the formal interview by turning on the recording devices, I spent a little time in conversation with each person with the intention of putting them at ease and so I could attune to how they were in the room with me – a direct consequence of my training as a relational psychotherapist. With the same intent, I took time at the end to wind down from the intensity of the interview and to give a chance for each participant to establish a closing boundary around the intimacy of what we had been speaking about. Though participants were encouraged to be in touch, either by phone or email, none had thoughts or concerns they needed to share between interviews or after the process had ended. One participant continues to check in occasionally with me by phone or email about progress in life – evidence I interpret to indicate that he found the process we engaged in to be both a relational and meaningful one for him.

Research questions were open-ended as this format allowed access more readily to accounts that revealed meanings, often hidden ones, interpretations, and constructions in the way participants talked about themselves and their experience of 'ADHD'. I was very aware that our interviews were being jointly constructed and my questions were intended to guide the discussion informally, rather than locking the participants into any rigid set of responses. I was mindful that part of what I could bring to our interview process was what I was valued for in my work with the NHS group of adults with 'ADHD' - being our collective memory and returning the discussion to where we were collectively focused if one member's contribution began to get too far off track. This had to be balanced against the potential benefits of 'going off track' where this might, in fact, lead to a 'thicker' description of participant experience.

Interview recording, storage and transcription

Interviews were recorded on both my phone and laptop simultaneously. This duplication

was to ensure that I would have a backup recording should one or other device not record or fail. Recordings of the interviews were kept in a password-protected folder on my laptop, on a password-protected folder in my Google cloud storage, and on a password-protected USB key which was kept in a locked file box. Again, the creation of several copies and locations for the recordings was to anticipate recovery in the event of any technical failures, such as might happen if a device got lost or damaged. Data protection was to pay respect to participant confidentiality.

After considering all the literature around the pros and cons of self-transcription, I made the decision to have a reputable transcription service transcribe the interviews. This would free me, I felt, to really engage with the meaning of the texts, as my experience of transcribing in the past is that I would turn off my cognitive awareness of the deeper and more implicit meaning of what I was transcribing, in the mechanical process of putting words down accurately on a page from a taped recording. Though I did not inform participants of this decision, the particular service chosen was done so on the basis that it had a great deal of experience with both university level transcribing as well as high levels of rigour and experience around file recording confidentiality. I was fortunate enough to bid for and receive a research grant from the United Kingdom Council for Psychotherapy (UKCP) which defrayed some of the higher transcription costs that resulted.

Making use of a 'critical friend'

I had earmarked a research 'buddy' as a credibility check and to support me in the initial stages of the research process by interviewing me. The purpose of this was to identify difficulties with the intended story-telling focus or process, procedural snags or design improvements needed which would in turn dictate changes to the planned format or interview schedule. The results of our interview did not indicate any need to shorten the interview time frame or change any of the questions as we concluded they seemed open-ended enough for participants to fill in with their own experience without feeling directed.

Another important consideration in this peer interview: I wanted us to look out for any potential power imbalance between my role as researcher and my role as the mother of an adult son diagnosed with 'ADHD'. I could have done this with a participant which would have reduced even further any potential power dynamics, but I had made the decision to disclose *my* experience of 'ADHD' rather than my son's, so this felt more respectful of his privacy.

I had spent the previous year in my personal therapy, preparing for starting the research and interview process, working on the conscious and unconscious feelings I had around my identity as an 'ADHD' mother. While some of those feelings remained alive and quite painful, as they evoked memories of self-blame and helplessness, my colleague and I did not feel that they were unrecognised in a way that was likely to be enacted in the interview process.

My interviewer asked me questions such as:

➢ What does 'ADHD' mean to me?

➢ What did the demands of a pre-schooler son, later given a diagnosis of 'ADHD', feel like for me?

➢ What was the loss of an imagined child like?

➢ What was it like to have mental health professionals not be able to help your son?

➢ What effect did caring for a son diagnosed with 'ADHD' have on your identity?

➢ What stands out in your story for you now that you have told it?

➢ What effect did caring for a son diagnosed with 'ADHD' have on your work life? On your family?

➢ Can you tell me a little bit about your son as a person?

➢ How do you imagine working with 'ADHD' going forward?

➢ What would you want people to know about 'ADHD'?

➢ What has been the biggest surprise for you about giving this interview?

What stood out in my retelling of my own story was how painful it had been to feel I could not help my son effectively as he was growing up, and how difficult it was to find

professionals who were knowledgeable, caring, reassuring and informative. The social stigma associated with 'ADHD' and medications at the time, and currently, remained vivid.

What I was also reminded of in doing the peer interview was that the whole topic of 'ADHD' remains a passionate one for me, growing as it does out of my own family's history, my son's difficult experiences growing up, and my desire to provide a forum for the experience of 'ADHD' to be heard. I knew that it would be important to be self-aware enough not to project any possible feelings of helplessness from my own history on to participants. At the same time, I knew that to deny my and my son's knowledge in the process of this research would not have led to a sharing of power but 'rather [to] a denial of its existence' (Etherington, 2000: p. 255). So if it came up in the interviews, I would disclose this personal reason as one of the reasons for my interest in the research area.

Ethical considerations

Research ethics guidelines of the BPS (2014) and the British Association of Counselling and Psychotherapy (Mitchels, 2018) were followed. Participants were informed that their interviews would be kept confidential and their identity anonymised throughout the process. In reviewing the transcripts, I took special care to disguise identifying information such as names of family members to ensure anonymity for the participants. Each participant was made aware that they could withdraw from the study at any time and that it was their choice what was to be done with any data collected.

As mentioned earlier, one participant did decide to stop after the first interview. She had found a new job, after a long difficult period of not working, and did not want any further discussion of a past that she found painful and disturbing to destabilize her. In discussing this with her I worked very hard to smooth her path away from any feelings of guilt about not continuing that were clearly close to the surface. The client was happy for me to use the first interview but did not want to complete the other two that had been intended. What she had revealed to me in her email was that while she had enjoyed talking to me in the first

interview, she had found it tiring and her mood problems had resurfaced for a few weeks which she attributed to the painful memories associated with the loss of her last job. That she had not made me aware of this until some months after the fact, despite my inquiries around her wellbeing at the debrief at the end of the interview, and in subsequent communications, challenged my sense of being an ethical *enough* researcher and made me doubly aware of how sensitive the research process can be.

It had been important to me to consider the impact of the interviewing process on participants and was a condition of the consent I received from my institution's ethics panel to engage participants in the research. Information was therefore available to them about possible sources of psychological support such as counselling professionals, as well as practitioners familiar with 'ADHD' diagnoses, whom they could consult if needed. Time was also given to participants, after the 'formality' of each research interview, to engage in informal conversations with me about the nature of the work or any feelings that came up for them.

The key ethical issues that were of concern in this study were those related to the confidentiality of and respect for the participants. Participants were fully briefed on what they were going to be asked to do and what general areas of their 'ADHD' diagnosed experience they would be asked to discuss. Consent in writing was obtained giving permission to record the interviews, as well as to having their interviews used in the study. Participants were also assured that any materials generated would be kept in a secure location and destroyed at the end of the project.

I was mindful that participants might make mention of third parties and details in their stories that could threaten their anonymity and perhaps risk compromising other individuals. With these complexities in mind I adhered to an ethical stance which focused on values and principles leaving room for 'a decision-making *process* rather than an application of proliferated rules.' (Stark, 1998: p. 208).

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Engaging with the narrative accounts

Once I had completed the interviews with the six individuals, the process was straightforward and kept in the forefront my ethical duty of care. Recorded interviews were transcribed with participants' names changed and all identifying details removed to ensure confidentiality. As the interviews with everyone took place over a year or so, the four participants who had asked to be sent their transcripts were provided with copies of these and offered the opportunity to correct or delete material if they felt this was necessary. None felt the need to do so.

I resonated with Polkinghorne's belief that the focus of qualitative inquiries is on describing, understanding, and clarifying human experience (2005). I liked the idea that 'accounts' was a more accurate term for the knowledge I was holding in each interview transcript than the more positivist-leaning term 'data' (Polkinghorne, 2005, McLeod, 2011). The transcripts were not just marks on paper, but the 'meanings represented in these texts' and 'the ideas and thoughts that have been expressed by the participants' (Polkinghorne, 2005).

At the same time I was also realising that the method of narrative inquiry I was drawn to saw it as a set of 'narrative principles and concepts, (which) for the most part, serve as interpretative guides rather than as 'theory' in the conventional sense.' (Hoshmand, 2005: p. 180). This suited my methodological philosophy well as I wished for each of the individual stories of the participants to be initially privileged over any generalizations about their collective experience of 'ADHD'. My inquiry can be understood more 'in terms of certain principles of analysis and interpretative templates that are not uniformly applied in a codified fashion' (Hoshmand, 2005: p. 182). Any view of the collective experience would come later when I hoped to generate useful therapeutic guidelines from across the six accounts – what Etherington calls 'looking across' stories after having already 'looked inside' them (Etherington, 2018, from written comments received on a draft of this work).

When it came to considerations of how I was intending to analyse the interviews, I found myself confronted with the impressive heterogeneity of applications that seemed to fall under the rubric of narratological analysis. Many of these techniques, such as the eighteen different ones outlined by Leech and Onwuegbuzie (2008), did not speak to me. Counting words to come up with word frequency was one example - the assumption being that the more frequently a word is used, the more important the word is for the person (Carley, 1993). Other analytic techniques such as conversation analysis, qualitative comparative analysis, even domain, taxonomic or componential analyses[4], all seemed, like grounded theory, to try to extract meaning and build theory by reducing the words on the page to quantifiable, and therefore conclusion-leaning, outcomes of meaning.

This left me thinking long and hard about what was important to me to do in the process of engaging with the interview transcripts. I kept returning to the sometimes held belief in early native American and Australian aboriginal cultures, that the act of having your photograph taken steals the soul and imprisons it in the celluloid. That sense of something sacred being transposed into another less respectful medium felt like an ethically genuine risk I was running. My challenge was how to most respectfully take participants' words and feelings as expressed by them in their own spoken language, turning them into what would essentially become my narrative account of their experience of 'ADHD'.

I was nonetheless buoyed by the knowledge that narratives are useful accounts because we so naturally gravitate to making sense of our world and ourselves by putting words around our experiences. Using a meaning-focused approach emphasises that the comprehension of meaning arises from listening first to the voices within each narrative (Chase, 2005) which supported my own preferred approach.

My goal then was to find ways to inquire into the interview stories so as to give an

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[4] For further details on each narrative analysis technique, see Feldman, M. S., Sköldberg, K., Brown, R. N. & Horner, D. 2004. Making sense of stories: A rhetorical approach to narrative analysis. *Journal of Public Administration Research and Theory,* 14**,** 147-170.

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account of the multiple levels of experience that would be both explicit and implicit in the narratives. Our life and self stories shift and adjust with time and context and salience. The best friends we have when we are sixteen are unlikely to be those we have at sixty, yet their presence in our lives influenced, shaped and changed us in ways both remembered and forgotten. It made sense to me to view each participant as simultaneously engaged in 'living, telling, retelling and reliving' their stories (Connelly and Clandinin, 1990) as they told them to me in our interviews.

Analysing the participant accounts is a way to understand the experience of a particular group of adults who identify with the symptoms categorized as 'ADHD'. More than this, an important feature of narrative is that it is 'constructed and embodies an active protagonist. It therefore represents an image of the person as a being who is an agent, who exists in time, and who can reflexively monitor the stories he or she tells' (McLeod, 1996: p.179). I began the engagement with the stories holding in mind what one view considers the 'three commonplaces of narrative inquiry: temporality *(backwards and forwards)*, sociality *(inward and outward)* and place *(context)*' (Clandinin, 2013: P. 39) *(my words in italics)*. In addition, I decided to add relationality as another commonplace. This was with the intention of not only paying attention to the participant relationships with self and other which is covered by the , 'sociality' commonplace, but to allow for my own relational perspective as a clinician on each person. As a psychotherapist-researcher, this is a critical aspect, not only of personal story, but also of the intersubjective relationship between us.

I began by reading the transcripts several times while listening to the tapes simultaneously. On the first pass, any errors, omissions, or misunderstanding of words or phrases by the transcriptionists were noted on the printed-out transcript. Preliminary annotations were made highlighting key points in the transcripts relating to temporality, sociality, place and relationality and written up in column format (see sample in Appendix 4).

Particular attention was paid to points that a participant returned to perhaps more than once across all three interviews, as I knew from psychotherapy work with clients that this was

likely to be providing a window into the implicit meaning-making that the participant was engaged in, as well as noting the explicit narrative flow that took into account life events in time and place. The variety of stories and themes that emerged from each participant's narrative was noted as well as the events or turning points that emerged from his or her life narrative. The approach intended was not so much to look for emerging patterns initially, but to connect to the richness and complexity of each participant's narrative. At the same time, I was reading the narratives with a view to pinpointing those experiences, negative or positive, that might allow me to extract helpful, sensitive and useful information to inform therapeutic practice going forward.

Reflexivity – the relationship between researcher and account

Something that I felt contributed to my capacity to maintain a rigorous reflexive stance within the process of the research was that I had chosen, outside of the research process, to work with 'ADHD' adults in my role as an integrative psychotherapist. This enabled me I believed to deepen my intersubjective knowledge and experience of 'ADHD', allowing me to develop a professional and dispassionate stance that I could utilise to good effect with research participants in allowing their voices to be heard. A potential limitation of this was that my clinical experience might make me more vulnerable to confirmation and/or selection biases, unconsciously filtering participant narratives through a clinical, rather than a participant, perspective. Nevertheless I concurred with the view that it was important that 'The researcher must use her knowledge to situate the analysis so that the reader can weigh the evidence with an understanding of the analyst's perspective in mind' (Finlay, 2002).

Being close to the topic could also have meant that I risked missing, under-emphasising or assuming aspects of participant narratives which either did not match my own experience or which I found, consciously or especially unconsciously, challenged that experience. As Etherington notes: 'Ideally a narrative inquirer comes from a 'not knowing 'position. Being a naïve inquirer, [means] not taking for granted that we know what someone else is talking about whilst also being aware of ensuring our own knowledge is not being used to fill in the

gaps of the participant's stories.' (2018, from written comments received on a draft of this work). While I felt that the medical model view of adult 'ADHD' cannot foreground individual experience, I wondered at the same time how easily might I embrace all that a relational prism might reveal about the behaviours, thoughts and feelings of those same adults.

When it came to how I wanted to tackle storying the participants, I reflected on some of the themes that had come up for me in remembering from the interview with my 'critical friend' what it had been like as a parent trying to support a son with 'ADHD. These were largely around the powerlessness of not knowing as a mother and a family how to identify, understand or manage 'ADHD' behaviours and the struggle to empower our son to do the same for himself; coping with the the stigma we faced as a family having a son who was 'different' when we all felt a great desire to just fit into the school and neighbourhood community; and dealing with the lack of appropriate professional support as we sought to create familial and educational support structures for ourselves and our son.

In responding to the participant narratives with my own narrative repertoires as inevitable background, it felt important first to tell each participant's life story with the major events as they recounted them to me to give their own context for their 'ADHD' story. In addition, since the focus of the research project was 'ADHD', culling out their specific experience of behaviours, stigma, professional support or lack therof would also be germane. How participant experience of 'ADHD' impacted their relational worlds was also attuned to the resonances of what had been challenges for me as a mother. Finally the training and knowledge that I brought from my professional world of counselling psychology and integrative psychotherapy could add immeasurably to the stated goal of contributing to the world of counselling psychology where it intersected with an expanded understanding of 'ADHD'.

Trustworthiness

Qualitative research methodologies are inherently subjective in nature, seeking as they do

to give validity to the meanings of experiences of individuals, not to the generalisability of their findings to a wider population. This however has raised the question as to how to evaluate trustworthiness in a qualitative inquiry and finding ways to establish credibility, transferability, dependability and confirmability are often among the most common criteria cited (Lincoln and Guba, 1985).

It was with this set of concerns in mind that I first chose to engage in the prolonged engagement with participants that three interviews would allow me offering a way to facilitate internal validity. I sought additional credibility by making a point of sending back transcribed transcripts to the participants in order that they could comment or give feedback, though none wished to do so and were happy with the outcome. Interpretation of the stories went beyond the participants self-understanding, as I was also looking at the stories through both a researcher and a psychotherapist lens with the intent of understanding their experiences facilitated by research and theoretical literature (Loh, 2013).

At points in the research process, as the interviewing began and as I was writing up what I had learnt from participants' stories, I discussed the process with 'critical friends', in some cases sending samples of writing, to get their critique on whether analysis intent was matching execution, and then making use of their feedback. In one case this resulted in adding my perspectives in the 'Context' and 'Reflections' sections to give the reader a greater sense of the person and character of the individual, as well as their impact on me and how they felt to me as we engaged in the interviews together. As the dissertation was nearing completion, I sent it to a senior research counselling professional, who has knowledge of and interest in 'ADHD', who validated what she was reading from her own experience. With a view to establishing dependability, I worked to elucidate as transparently as possible the process of interview collection, storage and accurate reflection of participant stories.

A final criteria of trustworthiness that I held in mind was the need for any qualitative work to be useful and applicable beyond the immediate content of the work (Loh, 2013). Part of

the gratification that grew out of doing this work was the extraction of therapeutic guidelines for work with 'ADHD' adults going forward that would be relevant to them, counselling training professionals, and more especially to interested counselling psychotherapy professionals.

Presentation of significant themes in participant narratives

The following six sections are presented in the order I interviewed the participants. The names given here are pseudonyms and are not those of the six individuals who gave of their time and personal histories to support this research. The same is true of any friend or family member that may have been mentioned who have similarly been disguised with different names. For greater ease of reading, I begin the presentation of each narrative on a new page.

For the purposes of clarity, I have taken out the overuse of phrases such as 'sort of', 'like' and 'you know' which often punctuated the spoken language of participants, but which made it harder to track meaning when being read as written text. This represented a choice point in the process as, from a discursive psychological point of view, doing so possibly ignored the use of these phrases as meaningful conventional devices, and risked distorting participants' meanings. I did instruct the transcription service to include all pauses, laughter, hesitations, um's and er's in the transcribed texts. It could additionally be argued that not choosing to videotape as well as audiotape the interviews meant that any non-verbal information to be gleaned from individual and interpersonal body language was not available to further thicken the narrative analyses.

Joe

The three interviews with Joe lasted 1 hour, 2 minutes (1:2), 1:26 and 1:8 hours respectively.

Joe was a married, 48 year old man who had had identified with 'ADHD' in his adulthood but who had not been able to be formally diagnosed until he was 45. He was an entrepreneur in the early years of getting a new business off the ground.

Narrative

Joe was the first participant that I interviewed. He turned 49 over the course of the interviews he did with me. He had initially been referred to me by the person who ran a grass roots local group for people, mostly adults, who identified with 'ADHD'. All his interviews took place at his business. He was open, honest, self-deprecating and present to me in the room at all times.

Joe said that both he and his parents had been born locally. The family moved to Norfolk in East Anglia when he was four, which is where he attended school. His father was a carpenter/builder for film studios, responsible for building sets. Joe placed himself in the family structure as 'the youngest of four children'. His family environment was chaotic. Joe suspected his mother was an alcoholic and suffered from mental health issues. From the age of six Joe was often given into the care of a male neighbour who sexually abused Joe until he was 11. Joe spent much of his teens and 20s having conflicted feelings about this relationship: '...he saw the vulnerability of me because of what was happening with my family.' Yet at the same time feeling that '...the sex was a very tiny part of our relationship.... for me, it was like an escape.... I love him to bits. He was very structured, and I knew I always wanted structure. And my home was chaotic.'

Joe's older sister died when he was ten – she fell and hit her head while they were playing hide-and-seek together. She was taken into hospital and died there within the week. This

was very traumatic for all the family. Joe's parents divorced, the house was split up and Joe had to change schools. Joe's memory of this time was that it was a 'living nightmare'. His brother bullied him, and his father was trying to commit suicide. Joe's memory of that time is that he was put on Valium for three years to cope with his depression and thus did not engage with school. He reported the years from 11-15 as lost years academically and felt this loss to his achieving self keenly, marking him out as lacking something essential compared to his peers.

Joe worked as a chef for a couple of years and 'hated it'. Then he travelled abroad. He taught English in Hong Kong for two years without any formal qualifications. He returned for a time to the UK, seeking out the company of bright, stimulating people, living in Edinburgh with some PhD students. He became a tour guide in Holyrood Palace. Throughout this part of his narrative Joe expressed the growing frustration he had felt at not being able to do things academically the way others appeared to be able to do.

It was at this time that Joe's anxiety became overwhelming for him and he began to feel he really had some kind of problem. He had to walk away from the tour guide job as the crowds were too much for him and he had started having panic attacks. His father paid for a ticket back to Hong Kong where he continued to teach English to Japanese businessmen. He met and married his Japanese wife, doing what he felt was the right thing after she became pregnant.

Not wanting to be an English teacher for the rest of his life, Joe returned to the UK on his own to prove that he could provide financially for his family. He was able to focus enough to study, getting an A in GCSE English. When his family re-joined him he got a job as a teaching assistant at a UK college and later was offered a teaching position there. He worked at this college for 14 years, part-time, teaching special needs students subjects such as numeracy, cookery, enterprise and life skills. He also opened a café on the campus.

Joe frequently attempted to gain further qualifications, so he could either get promoted

or move to a different job but failed and ended up leaving the college due to stress. He endured 'a bit of a tight, lean six years really', working with Job Centres to find employment, even at one point trying to find work again as a chef – a 'young man's job'. When I met Joe, he was well into the process of setting up a business as an entrepreneur which he hoped would marry his love of teaching, his knowledge of food and education, and his desire to help children and adults with special needs.

'Like a cut that never heals'

Joe always believed that there was something different about himself:

> 'I didn't know what it was. And there's this constant searching for what it was. It's like that…. it's like the cut that never heals, really. That's how it's like. And it's hard to describe it to people who are not professional, who will not think, 'Oh no, you'll just skip around it.' Well no, you don't. I'm sorry. It doesn't change. It's a constancy there that doesn't change…'

He was well into adulthood when a neighbour suggested he might have 'ADHD'. He said that he had not associated it with himself as the prevailing knowledge of 'ADHD' was all about hyperactive little boys. By contrast, it was his childhood daydreaming and inattentiveness that came to mind.

As an adult Joe is very uncomfortable around lots of people whether in social or work environments:

> 'I didn't like sport. I don't like gatherings of people. I don't like parties. Well, I've done it. I've been to big cities and I've done all sorts of things. But even today, I find big gatherings quite challenging.'

> '…this is interesting because I can teach in a classroom, that's not a problem. …I found it hugely challenging in staff meetings and even more so in

staff team days. …The amount of people there, the amount of people you have to be involved (with). You had to stand up sometimes and … sometimes I didn't. I actually took off sick because I couldn't actually attend, I found it quite challenging.'

The part of education that Joe he has always found difficult is the theoretical side:

'…I can teach. I can deliver, you know, it's just the theoretical side is challenging although I read ferociously. It's just getting it down on paper is not the easy way.'

Time keeping has always been a source of anxiety for Joe:

'I'm never late. I overcompensate for that. I know I could be late. But there's always an anxiety there that I've got to be there.'

'I think I just see things a bit differently…'.

Joe has a strong sense that he seems to lack some capacity for interpersonal understanding:

'And I don't think I interpret…I think interpretation is also very different, the way I interpret stuff sometimes. And sometimes understanding how to interpret, I find it difficult sometimes as well.'

At the same time Joe's need for stimulation marks him as someone who researches intensely and is curious about so many things:

I'm forever looking at all sorts of things. There's this constant stimulation you wanted all the time, you know.'

Job hunting for Joe has been an excruciating experience. This is particularly exacerbated

by the rise of technology. Joe remembered getting his first teaching job through chatting with someone in a corridor at his college. Now his 'ADHD' works counter to what is expected:

'The way you find work is different …all the websites, all the jobsites, it's huge and challenging for anyone with 'ADHD'… for anybody. And then the application form again, it's like oh so long. Trying to focus on the task of actually filling out the application…'.

He chose to take advantage of the disability classification he could claim with his 'ADHD' diagnosis, as the 'mainstream' support staff at Job Centres could not understand him, even though he had always had mainstream jobs:

'…what I really wanted was tangible, hands-on, one-to-one support, help me with applications. But they just leave you to get on with it.'

'And I think, … if you can get, I mean, the right person working with you, then actually you can achieve so much within the workspace.'

Joe finds multitasking virtually impossible:

'I wanted to do a creative writing degree. And I could probably do that… It's just I need to have total space to do that. …. There's people who juggle work, and a degree and everything else, I couldn't do that. It's either all or nothing. I can't do anything else apart from this.'

Joe knows that external structure is helpful for him, 'because of the chaos in here' (pointing to his head). In his first experience talking to a therapist when he was around 30, that was one of the experiences of his 'ADHD' that he tried to articulate:

'The conversation started with him and said I felt like I wanted to drain my brain. It felt like I wanted to actually literally drain my brain out. And then he said,

'What does that make you feel? Do you feel dirty then?' It wasn't that! And that's really the first time, looking back now, that's 'ADHD'.

The therapist confused his attempts to talk about his 'ADHD' with the disclosure of his sexual abuse, but in doing so, Joe was able for the first time to distinguish between the two experiences. Because he had not been feeling bad about the relationship with his abuser, he recognised something significantly different about himself that he was beginning to identify with as a hyperactive brain.

Even though he is anti-medication and is trying to find other means, such as nutritional methods, to treat his 'ADHD', traditional medication has made a difference for Joe:

'But at the moment it is making me achieve. …. Yes, it's quieting. It's quieting the brain. It's quieting things, so it's more controlled.'

'…I suppose I've never felt like this. Well, I haven't felt like this for years and years and years and years. I don't think I've ever really felt that confident in life, personally.'

The perennial odd man out: '…I wasn't valued for such a long time.'

Growing up with a set of symptoms that were not well understood in the aggregate, but which were nevertheless judged by society, created consequences in Joe's capacity to accurately self-evaluate: 'Am I clever enough? Am I worthy enough? Am I adequate enough with what I am trying to achieve really?'

The experience of feeling he was different in some way meant that Joe grew up not knowing where he fit in:

'I doubt myself all the time. There's doubt. Low self-esteem. Anxious. That's me. Always have been.'

Being diagnosed with 'ADHD' has allowed Joe to make meaning of himself to himself:

'Well, I think I'm beginning to understand myself and I'm beginning to understand...how I work, finally, and what's best for me. But trying to tell people what's best for you is not an easy thing sometimes. So...it's like I've been going through life and trying really hard to fit into life, but it doesn't work. ...I think finally what' I'm doing, I'm now making life fit somehow.'

In the past, Joe had to contend with a medical system that was built to treat conditions separately, not try to understand symptoms holistically. At various points in his life, assumptions he found very frustrating were made about which condition he needed treatment for: depression, anxiety, 'ADHD', sexual abuse:

'I've been going through mental health services who haven't got any specialists and they just look at the actual mental health and anxiety without addressing the 'ADHD'.'

'My God, (I'm being told) I've got this, this and this. And I thought like: 'No, I don't think I have.' I read all the specs...no, I don't. I don't have those. I've got lifelong friends, I have work, you know, all these things. I haven't abused myself...'

Why do I have to fight so hard to get the support so that I can keep on contributing to this society? Because what that does, it puts the burden on the victim, if you like.'

His experience growing up was of a split between two worlds, having two lives: the paradoxically organised, 'safe' world of his abuser and the chaotic world of his family. His adult self acknowledged that a line had been crossed with his abuser who had groomed him so successfully, yet:

'…(he) saw something different in me. He felt I wasn't getting the education I should've got. He saw there's an ability that they're not seeing, you know? He took the time. …and I suppose to have that attention purely from someone was actually an amazing thing to have.'

In Joe's experience, his family always suppressed his curiosity and incessant questions:

'I actually felt I'm in the wrong family sometimes, I do! …. They just don't see me at all. …They don't understand me, even now they don't understand me.'

Joe gravitated towards those who would accept him despite his differences. He pursued getting a formal diagnosis of 'ADHD' and when he received it from a sympathetic research clinician he burst into tears because finally: 'I felt someone believed in me!'

'The consequences of losing five years of his formal education had a devastating effect on Joe's self-image:

'I didn't have it. I had up until 10, but those years are completely lost to me. Was the time which is the most crucial in some ways, to learning all the how's: how to study, how to do this, how to do that. …I've only got up to 10-year-old how to learn! Well, it didn't happen with me. And that's the bit I want back.'

The consequences to self-worth have been profound:

'I don't feel I'm as good as other people. I don't feel I'm worthy to be there (at events with others).'

'I also believe you need to value people and I wasn't valued for such a long time. It really eroded me as a person, and you can't do that to people. Value is an important part of what I am.'

In the present Joe was intensely committed to making a difference, as a direct

consequence of knowing how difficult it was for him to progress given the chaos of his childhood, the confusion of his early abuse, depression, anxiety and the pain of the 'lost years' in his childhood. There had been a price to pay:

> 'I really had to adapt so much in my life to change. But the price has been, I think, anxiety. I think it's been hugely anxiety-making. Because it's one thing to adapt when you feel safe. It's another thing to adapt when you can't rely on an income, you know, where you can't find a job, when you can't do things that .... everybody else seems to be able to do.'

> 'I think 'ADHD' does really play havoc with one's dreams and one's hopes and one's sense of achievement and what one can do in the world, you know? But I think I will try to achieve now.'

Analytical commentary

At the end of our final interview together, Joe remarked about what the process of talking about his life through the prism of his 'ADHD' had meant to him. It became clear that we had been engaged in a process of co-created meaning-making that was in fact alive and goongoing: 'I wanted this sort of thing for such a long time, wanted it, desired it, whatever....' and 'I thought it was about my sexual abuse and I think it isn't. It's actually about 'ADHD'.' 'Actually the problem, in some ways, it has been the 'ADHD' really. And this has really helped me understand it a bit more.'

Throughout all three interviews, Joe was anxious to give me what I wanted and frequently checked in that we were covering what I needed from him. He was energetic and expressed his feelings freely, often being moved to tears when thinking about the losses he felt keenly, particularly the gaps in his education. He came across as a deeply principled and caring person and his business model, supporting special needs children, exemplified this.

Joe's story was dominated by the past. He had had a succession of family traumas that

thrust him into the arms of someone who paradoxically represented a self-object who offered him stability and structure and who confirmed his 'innate sense of vigour, greatness and perfection' as well as someone to whom he could 'look up and with whom he c(ould) merge as an image of calmness, infallibility and omnipotence' (Kohut and Wolf, 1978: p. 414). However the abuse of a father figure is one of the most damaging kinds of sexual abuse (Browne and Finkelhor, 1986) and 'ADHD' children are particularly vulnerable. In one study, 'ADHD' was the second most frequently diagnosed disorder among a population of sexually abused children who carried a primary diagnosis of PTSD (McLeer et al., 1992).

Joe's sense of himself as having failed educationally was a huge factor in how he perceived himself and contributed to an underlying fear that he was 'stupid'. Like many adults with 'ADHD', Joe felt like an imposter, struggling to hide his inadequacies from colleagues and family (Nadeau, 2002). People with hidden disabilities are often engaged in a unique and almost exclusively private and internalised struggle in an attempt to preserve the personal and occupational 'self'' (Fitzgerald and Paterson, 1995).

Joe's personal fulfilment came from the relationships he was able to create helping people, both his loved ones, and the children and families he worked with. He used his capacity for determination to be dogged about solving problems, including his own. I found it very easy to warm to Joe. His openness was both overwhelming and poignant.

Harry

The three interviews I did with Harry lasted 1:36, 1:14 and 1:43 hours respectively.

Harry was a 30 year old political analyst whose uncle had suspected when he was a child that he had 'ADHD'. His considerable intellect allowed him to achieve academically in school, belying this construction of the organisational and attentional demands he had experienced once he began his work life. Both his parents were dead, he was divorced and not currently in a relationship.

Narrative

Harry had been diagnosed with 'ADHD' when he was 29, approximately a year before our first interview. He had heard about the research project from the facilitator of a local grass roots 'ADHD' self-help group that he attended occasionally. We met for each of the three interviews in a room at a newly opened private 'ADHD' Clinic, designed for the assessment, diagnosis and treatment of children and adults self-referring or referred by their GP.

Harry and I met in one of the sparsely furnished offices in the clinic, and we were initially sitting, me at the 'doctor's' desk, he, in the 'patient' chair. I found myself aware of the power dynamic that this lent to the interview setting – me as authoritative professional, and Harry as a person seeking something from me. I asked if he would mind if we could move to sit opposite each other in softer chairs around a low table in another section of the room, joking explicitly about the roles the furniture arrangement seemed to dictate. Harry politely agreed, seeing the point but not really letting me know what his real feelings might be.

Harry had written in his introductory email to me that he had been diagnosed with''ADHD'-PI'. The 'PI' part of the label indicated that tests had shown that he was 'Predominantly Inattentive' as opposed to one of the other two classifications under the DSM-5 system: 'predominantly hyperactive-impulsive'' or 'combined' type. There was a precision to his description that conveyed a sense of containment. It was clear that he

wanted to help in the research.

Edward presented as a slim, self-contained man, slightly shy appearing, who was articulate, thoughtful, and considered in his speech and conversation. He did not exhibit much affect, even when speaking about life, familial or professional situations that had clearly been stressful or anxiety-making for him. It was as if he did not wish to put me out in any way and even when I asked something he did not seem to find relevant to his own internal narrative, he would work hard to find me an answer that would address the question.

Over the course of our interviews, Harry told me that he had been working as a consultant for a political risk firm for the last three years. He had a sister, three years younger than him, living in the US. Both his parents were dead. His closest relatives were an aunt and uncle who were around during his childhood and adolescence but had moved to New Zealand.

Harry had clearly done a lot of research into 'ADHD' and was fairly certain that if one of his parents were to have been the genetic parent for his 'ADHD', it would most certainly be his mother: 'She is a really sad story, honestly'. This seemed to be related to the fact that his father had died from cancer a month after he had been initially diagnosed when Harry was 13 years' old. Harry matter-of-factly expressed the opinion that this had been devastating for his mother, who became depressed, and later alcoholic, and remained so for the rest of her life. She died ten days before Harry's marriage, to a wife from whom he was now divorced. That had been six years ago when Harry was 24; ten years after his father's death.

Harry grew up initially in a little village in South Wales. His father worked as an electrical engineer. He went to the local primary school, and for a couple of years, the local secondary school, until the first of many subsequent moves occurred. He was very bright, and his academic precociousness meant that for much of the rest of his schooling, he was put in classes with pupils two years older than him. This did not help him build age-appropriate social skills.

Harry's school life quickly became a peripatetic one. His father's job was threatened, and his parents made the decision to study and qualify for the licensing needed to become publicans. They applied to various places in the north of England but eighteen months into running their first pub together in Yorkshire, his father died. Harry's mother continued to do that for a couple of years but found it too exhausting. Harry felt that she was 'grieving enormously and enormously depressed during that time.' He and his sister and mother spent a year living with his grandparents and then moved to various other locations including a caravan park. During this very disrupted period Harry attended four different schools some of which were good and some bad. The only one that he remembers really enjoying was one where he was put in a class with children of his own age.

Life with his mother during this period was unstable. At least three times he was sent to live with his uncle and aunt and their family for a few weeks at a time. They were a strong source of support for him. Harry craved the stability they offered. His uncle worked 'regular hours' in the IT industry and his aunt worked part time. They had the proverbial 2.4 children. They lived in an affluent part of the country. For Harry it was 'just very, very stable. They were able to try a lot harder than my mum, for obvious reasons.'

When he was about 13, Harry was sent to boarding school, a comparatively long way away from where his mother and sister were living. Though he appreciated the stabilising discipline of the school's routine, he was so homesick that he chose not to continue after the first year. He suffered from frequent migraines and remembers being shamed by the school nurse who suspected he was faking or exaggerating them. He left secondary education without any GCSEs, but 'blagged' his way onto a course to study for his A-levels at a Further Education college and did his English A-level in one year.

Eventually Harry made it to Oxford and completed a degree in English. He was offered a post in his current firm but after the first year or so found the stress of managing some of his symptoms – forgetfulness, inability to focus on demand, knowing somehow that he was different in a way that he could not make sense of for himself and therefore could not justify

or explain to others – very stressful. This led to him having to work part time for about 18 months, as he dealt with the resulting disabling anxiety and depression. Once Harry got diagnosed with 'ADHD' life had immediately begun to turn around.

Harry's experience of 'ADHD': 'Just firefighting all the time.'

By chance, a friend who had been diagnosed a few years earlier suggested he might have 'ADHD'. The subsequent assessment, diagnosis and successful outcomes with 'ADHD' stimulant medication transformed Harry's life.

Harry was clearly very proud of and reliant on his high intelligence level:

> 'I was reading at two and writing at a similar age. I could do basic maths very early. Those were all reasons I was advanced, but they gave me the ability to do stuff quickly. And I think that papered over the cracks.'

Earlier on before his diagnosis he struggled to account for the differences he perceived about himself, and the talents attributed to him by others, which he could not always rely on himself to follow through on:

> 'It goes back to the whole idea that I was different because I was clever and so I had difficulty relating to other people because of that. You know, I was operating on a different intellectual plane, which is complete nonsense.'

> 'It goes back to people's expectations of my abilities. That I could pick things up quickly, that I could do things well. …. Because I was always against the idea that I was this intellectual savant who couldn't exist in the real world. That was something I tried really, really hard to not be that person.'

> 'It was always drilled into me that I was capable of doing things that most other people weren't capable of doing. But it's just the execution of those things,

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and knowing that I do it consistently, and if called on under pressure, I can do these things.'

Harry knew that there was something missing:

'I'd achieved very well academically. But I couldn't do this thing. I couldn't organise myself. I couldn't keep track of time. I couldn't…. administer my life in the way that other people seemingly could. …. then you add on the things, that you know, the promises that you don't keep, and the task that gets left undone because I'm in a hurry….'

Harry had had to contend unaware with ungovernable symptoms for as long as he could remember:

'Growing up with 'ADHD' without realising I had 'ADHD' was obviously very difficult. There's a lot of individual things with 'ADHD', I found you can make lots and lots of excuses for these things.'

The kinds of things Harry could make excuses for were being late or losing his pencil case on the first day of school which he had felt very ashamed about. He would fail to keep a track of his homework and at each school he would notice, after the first few weeks when not much was being expected of him, the teachers 'getting aware of the fact that all isn't necessarily right with me, so they're maybe keeping a closer eye than usual.' For a long time he and the world found explanations for his behaviours in the early death of his father, the constant changes of school and his home environment. But Harry knew at some level that these explanations did not really add up:

'(They) left me with a very, very difficult perspective because, fundamentally in here (pointing to his head) you know something else is going on. …. I mean not even know, but suspect, just on the basis of there being no correlation between how upset I was, or how much grieving I was supposed to be doing, and how

much disruption I was getting in my day to day life and the things I just wasn't doing.'

Time and again he would start a task or homework but after a few weeks be unable to sustain his interest. When he could not do homework the night before, he would do it five minutes before the lesson or in class. Or he would not be able to do his homework at all and have to come up with ever more creative excuses for not doing it which built up 'pressure and shame and guilt and all of these things.' Lessons were experienced as having to do work that Harry could 'do in my sleep' but which dragged out over the course of an hour in an environment that was just not stimulating enough. The combination of the stress levels and the essential tedium of going to school and doing basically the same tasks every day resulted in his migraines and being off sick after two or three days due to the stress.

'When I went several days in a row (to classes) which didn't happen that often, but occasionally did, it was exhausting. Eight hours a day, lunch and break times were not break times at all. That was, if anything, worse than being sat in a classroom and given something to do, just being set loose and told to eat something and being given nothing to do, was really difficult. …. Doing nothing is a really painful experience.'

'It was a cycle of needing a very stressful situation in order to function to capacity and that taking its toll on the rest of my life.'

This was why the intense structure at Oxford university worked so well for Harry:

'…the terms at Oxford are very intense, like they're eight weeks. They're short and intense. And I think both were really helpful. It was the sort of level of intensity at which I operate in times when I'm doing things productively.'

Socially Harry had to cope with losing his train of thought in the middle of saying something to somebody:

'I found ways to get around that when I wasn't medicated. I'd end the sentence with a platitude or something or just drift off and assume that the other person gets what I'm saying. …. Everyone does do that to some extent but, you know, it's to a much larger extent and that's what differentiates 'ADHD' from non-'ADHD', in a sense.'

Harry found writing much easier than verbalising. He experienced a kind of brain paralysis when he was required, or felt he was required, to put together a lot of different experiences and present them. Writing allowed him to go back and rework his thoughts on paper.

While he was familiar with the process of hyperfocusing, he experienced it as something that happened whether you wanted it to or not:

'It's not something you can turn on and off. It's not a skill you have to use. And it often gets in the way with other things, you know. It's almost like a lack of agency.'

He found playing video games gave him a lot of transferable skills: 'it's sort of big picture thinking, strategic thinking, and that's sort of something that transfers across into aspects of life as well.' Video games offered him the rewards of immediate gratification, but almost more importantly allowed his brain a rest:

'It is like one of the few things that I found genuinely relaxing. Like sitting in a corner doing nothing is not usually relaxing. It's like low input environments are just not relaxing.'

Noisy environments made it very difficult to focus on individual conversations. The amount of overstimulation led to intense distractibility:

'…like it's something shiny, you know, it's like you get drawn away. Looking at people when they talk to you is distracting because lots of things happen. You

pick up on all these social cues and most people can drown that out and focus, and I definitely do not.'

'...it's not a finely tuned sensitivity. It's just a sensitivity.... I pick up on these things and feel very keenly that it's a sort of misreading of what's happening. So I think that's, for me, what makes it difficult.... and exhausting as well.'

Having had a good response to medication allowed Harry to engage fully in his life in a way he could not before:

'The difference was extraordinary. .... Just like an energy that I didn't have before. It's really hard to describe because it's not strictly an energy. It's a sort of calming influence.'

'Given how effective it's been, it's basically getting my life back. I don't think that's an exaggeration. I think I was pretty well on my last chance at work. I would've been shown the door, I think.'

'It's like someone in my brain, just sort of being: 'This is OK. You can handle this. This is what you need to do. This is what you need to do next. This is what you need to do next.'

'This was one of the weirdest things when I was first medicated. It was just, I'm just the person that I want to be suddenly, you know? ...just like almost overnight [I] was just very clearly able to work. Just for however long it lasts, it was eight hours because it was two doses, just able to do my work and it was just extraordinary.'

'It feels like the sort of energy that I don't have before. I do this... like I walk. When I'm not medicated, I'm very hunched over. It seemed to be an effort to walk down the street. When I'm medicated, it's much more: 'Let's go to that

place!'

'Before I knew what 'ADHD' was… I saw all of these….behaviours…like moral failings.'

Because there were no words for the cluster of behaviours that Harry struggled with, and because he was internalising social, cultural and familial codes of conduct he could see he was failing to adhere to, Harry's observations of his own incapacity to live up to those standards caused his internal meaning-making about himself to break down. It was an inevitable *reductio ad absurdum* to end up judging himself as not only lacking something, but worse, culpable in ways he could not really understand:

> 'Before I knew what 'ADHD' was…. I saw all of these things, these behaviours. At best it's like deviations from the norm; at worst it's like moral failings. Like this is me not being conscientious enough. This is me not caring enough to follow through on the things that I said I would do. That I haven't found time to do it because, guess what, I was playing video games. All of these things were seen in that light. And that's a real struggle that does really hurt your self-esteem.'

> 'You see how people in the world operate, and you see the responsibilities they are able to fulfil, seeming happily without any sort of reward… just because they've said they'd do this thing and it's through moral duty or civil duty that they do these things. And there's always been a gap there.'

> 'It's not just a problem with how the world reacts to these things. These things are problems. They have actual consequences. If something doesn't get signed off, then people don't get money and they suffer because they don't get money. …And so to properly perform a function in society, you need to be reliable. You need to have these skills. For me, that's definitely the biggest impairment. …. There's lots of parts to that. There's the whole macro, can I get out of bed this morning versus another micro, I'm so exhausted after doing 2

hours of interaction with people that I just need to lie down, and I can't do the thing I was asked to do 2 days ago, for today.'

'And the stress was a lot, and I was very, very anxious during that time, because I didn't know how to fix it. …. It just wasn't something I could fix which was again why discovering 'ADHD' and being made aware of what it does, was just, I mean, it was almost like a dream.'

Harry's initial reaction on discovering he had 'ADHD' was directly linked to the sense he could finally make of himself:

'This is amazing! I'm really happy that I'm discovering this. I'm really happy this is the reason. Because when I thought of…. It was quite a dark place thinking about what the reasons might be.'

'I feel much better about myself. It's hard to put my finger on exactly why. Partly it's the knowledge about all of the things that I thought were moral failings were in fact chemical imbalances of whatever kind.'

Analytical commentary

My felt sense of Harry was that he lived at one remove from his feeling self which only came into the room in the form of mild humour. If I imagined Harry laughing uproariously or crying freely in front of me, it felt a bit shocking, as if verging on the unhinged. He was used to isolating his thinking from his feelings and his abstract thinking seemed very well developed, making me mindful of the cognitive style characterised by the schizoid character elucidated by Johnson (1994). Harry's predominant concern was located around whether he feels, and is perceived to be, reliable, especially in the workplace. This speaks to a basic underlying feeling of terror associated with failure to make it in the world that partly characterises the schizoid character (Johnson, 1994).

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Harry had been engaged in a re-evaluation of his past since he has been diagnosed. So much more of himself and his behaviours now made sense. He was embracing cautiously the prospect of engaging in a directed future. Harry's memory of his past was that he was 'just firefighting all the time and not really [having] any sort of big picture thinking at all.' But though he still believed that in nearly every case 'ADHD' was a disadvantage, he felt a compelling advantage in being able to put 'so many pieces of the jigsaw puzzle together about me and my life.' 'ADHD' was a series of obstacles to overcome. But Harry was energised by the feeling that he now has the means to overcome them which had given him a much more optimistic outlook on life:

> '...my place in the world is much more concrete and I can look at where I am and make plans about where I want to go. Whereas, again, I didn't do that before at all.'

Edward

The three interviews with Edward lasted 1:13, 1:37, and 0:42 hours respectively.

Edward was an unemployed 61 year old aspirational entrepreneur. He had had a successful early career but suffered a painful divorce in his 50s which had resulted in the loss of his family life and identity. He was currently in a long-term relationship and working to discover more about himself since his self-identification and subsequent diagnosis of 'ADHD'. He was intent upon finding the right niche for himself that would work in harmony with his professional strengths and weaknesses.

Narrative

Edward was 61 when he and I met first. He preferred to be interviewed in his home, and his partner, housekeeper and cat would once in a while poke their heads into the living room we sat in overlooking a pleasant garden and be firmly and kindly shooed out by Edward. This mirrored his narratives that were often interrupted by Edward himself as he shifted from one train of thought to another. Edward had thoughts about everything.

Edward had been brought up in London and has one sister, three years older than him. His grandfather had been in both the great wars but returned from World War II with no money and no income. Edward reported that his grandfather felt that the world owed him something because of his service, but he was only offered menial jobs and refused them 'because he was arrogant and above that', according to Edward.

As teenagers, Edward and his sister thought of their mother as 'totally self-centred and selfish'. I had a sense that perhaps she suffered from more than the severe depression Edward knew about. He said that she had always had the feeling she didn't have enough, was hard done by, losing friends and opportunities all the time. Edward found her a 'challenging person as a mother.' The feeling I got was that there was a great deal that was either being left unsaid, or Edward was unaware of, in his understanding of his mother.

School had also been challenging. He and everyone else knew he was bright, yet even in the art classes he loved, he would spend most of his time outside of them, banished for being 'naughty and disruptive'. He failed his 11-plus and remembered that his headmaster could not understand why as he was thought to have what it took to pass. On this headmaster's recommendation he was sent to 'an odd little private school' where 'they crammed you with work'. To Edward, this was 'like a rescue'. It was good for him because it was very structured, 'even detentions were structured', and he would spend break and lunch times copying out physics books as his punishment. But he enjoyed this and received compliments from his headmaster for his work. He worked hard there but 'got myself a bad reputation'. He then was sent to a comprehensive school where there was no homework, no structure and Edward 'fell apart'. He turned to his social life, reflecting: 'If you don't have structure, you have excitement.'

Edward left secondary school with no exams. He then went in to Civil Engineering and loved it, but found it isolating being on construction sites and 'away from life' - which seemed to be a euphemism for not having access to an active social life. He then started a degree in Urban Land Economics continuing his propensity to whoop it up socially. At the end of his second year, he decided to visit his sister and her husband for the summer in New Guinea where they were teachers. Prompted by the festivities around New Guinea's first year of independence he stayed on for another month but on his return he could not get himself back into the swing of things. He failed his end-of-year exam. Edward said that he played around for that year, did nothing about preparing for the resits, tried again and failed again.

Edward had really liked the law part of the course and was good at remembering outcomes and their application. His law lecturer got him a job at one of the top London arbitration firms and he thrived there for about seven years, becoming the best paid arbitrator and negotiator at the firm. He had a lot of secretarial support for the detail parts of this role. It was during this period that he married and started a family. However when he was refused a requested increase in his salary he went off in high dudgeon to another firm,

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where he did not succeed as well or find as satisfying.

Edward was made redundant and was just getting started on his own practice when he discovered that his wife was having an affair. Their subsequent divorce and break up of his family broke something in him. He had his first experience of medically declared depression. His attempts to set up on his own as a commercial property consultant failed, and he switched to marketing and business networking but soon realised he was not operating very well. Not seemingly able to get any results in any of these new ventures sent him into what various GPs kept telling him were more bouts of depression.

But Edward felt that something else was going on and after researching and going to a self-help 'ADHD' group, he thought that 'ADHD' symptoms more closely described his internal experience of himself than just depression. He fought hard and pushed his GP to refer him and eventually was diagnosed with the condition. This opened up a period of self-examination that Edward was still in the process of coming to terms with.

''ADHD' people...we are very resilient and we...get knocked down, we go back, and we go back, and we go back.'

Edward's relationship with his 'ADHD' was relatively new, in the sense of having only been diagnosed and given that 'label' the year prior to our first interview. He had known for quite a while that he was dealing with something else besides depression:

'Because depression didn't answer the question of why I just couldn't move forward. I just seemed to be blocked. I couldn't really explain what that block was. I was somehow not able to move forward.'

'But I didn't know what the something was I had to do something about and didn't know what the something I had to do was either. So I think I did get very depressed.'

His partner provoked a realisation when she remarked that he was always saying that things were going to get better, but that that never seemed to happen:

> 'It was the first time I'd stopped to properly think about it. So I reflected on that and I didn't know what was happening, but I could see that I was being confident for no good reason when I was going backwards when I was bound to go forwards. So that was a kind of turning point.'

He did a lot research on Google, promoted by a friend who had been diagnosed with 'ADHD' the year prior:

> 'And suddenly I got something about 'ADHD', I can't remember what it was, but I saw it on the Internet, with a description and a lot of questions and… it is very familiar, and it's suddenly that 'Oh my God! This is me! …And so I read about that and I read, and read, and read….'

The 'internal driver' experience often described in the literature about 'ADHD' played a big part in Edward's response to the knockbacks, even if it did not give him any real capacity to follow through on forward movement that would lead to somewhere that was occupationally constructive:

> 'It was because I was operating on my own, doing all these different things, all very exciting but actually, I wasn't very good at putting things together and making them work.'

Edward initially found that he put a lot of hope into medication, desperately wanting it to solve his occupational difficulties. When it didn't make much of a difference:

> …I got a bit panicky about the idea of…. If all that's on offer in the UK through the NHS are medicines and nothing else, that's a bit panicky.'

He had spent time reframing his past around what he could now identify as his own

'ADHD' symptomology:

The difficulties in his relationship with his depressed mother:

> 'And I would guess now that a lot of that was 'ADHD' because I was probably just always being a nuisance in that context.'

Having to enter input on a computer in a job environment or manage tasks that are boring:

> '…I'm so clumsy on the keyboard. It takes me longer to correct my typing than to type it in the first place. But naturally, I tend to type very fast rather than do it slowly.'

> 'And you've got to do accounts and type and all these other things that you're not very good at, they are a distraction. They get very frustrating and they just cause the sort of downfall.'

Impulsively leaving a good job:

> 'And I just thought maybe I've done something silly here but I just kind of needed that change. So if I'd been less impetuous, I'd have probably stayed there.'

The impossibility of organising anything:

> 'What I was always doing, just tying up and putting things away like moving furniture around, getting rid of furniture and replacing it, getting rid of filing cabinets, getting rid of the files. …Again, the odd thing I didn't know was that the last thing I should've been doing was trying to roll that structure forward and to be administered by me. What a mistake that was.'

But Edward found the label of 'ADHD' stigmatising – for him it has three negatives in the title – attention deficit, hyperactivity, disorder. He would like to see a change in perspective:

> 'I'd like people to know on a spectrum that it's not a disability. Potentially, it's an ability and I'd like people who are not on the spectrum to understand that they, too, have a brain type. ...And you can't put 'ADHD' people in a group, in a corner room. If anything, they should probably be in the middle of the room.'

In what he saw as his glory days, he used to dictate memos to his secretary who would transcribe them. He never looked at them again but would remember the content for meetings exactly. '...they would do all the write-up, the boring stuff. And that sort of stuff I'd always make silly mistakes on. So that would all be done, so all I had to do was think.'

Edward had re-evaluated his education:

> 'So I had read a lot of typical characteristics of 'ADHD' and sort of recognised the bits that were me. And I didn't think hyperactive until I looked back at my childhood.'

> 'Now looking back, it looks very peculiar to think that I was like that (disruptive in class) .... I often got top marks and was competing for top subjects. Usually doing pretty bad in exams, nearly always doing pretty badly.'

His success as a surveyor:

> 'And so now I can look back, that makes perfect sense in the 'ADHD' sense, because I was just completely absorbed, but had lots of fun at the same time, so I had the best of all worlds.'

His failed marketing venture:

> ...had I known what I know now, I probably wouldn't have started down that

route at all. But I don't know what I would have done, but I'd have found a safer route. So I've basically had 15 years of deconstruction.'

What he is, and is not, good at:

'I'd have recognised why I was doing so well. It didn't occur to me I was doing well. But I'm always on to the next thing, you know? I think it's probably more a matter of putting the past behind you because it hasn't worked, so you move on to the next thing and on to the next thing, and you just keep pushing, and pushing, and pushing forward.'

'If I'm focused on something, I'll stay focused. It's just that when you're self-employed, or not in that highly, highly supported, well-looked after environment where you only have to do your…most loved thing. …And you've got to do accounts and type and all these other things that you're not very good at, they are a distraction. And they get very frustrating and they just cause this sort of downfall…. you don't do them very well, so you mess them up and they take twice as long because you're just thinking about the main thing all the time.'

Finding ways to cope: 'I realised that a lot of survival is just not allowing yourself to feel or have any concept of pain.'

Being challenged by so many failures in his occupational life forced Edward to try to find out why he was not able to progress the way he thought he ought to be able to. This led to him having to go back and make sense of some of the ways he had developed to cope:

'…if as a child you have unrecognised 'ADHD', so you just grow up with this thing, with things going wrong, you just get used to it. And it's the only way to survive, that is to just pick yourself up and move forward and not worry.'

When he failed his A-levels and watched his friends go off to university without him:

'I didn't really know what expectation I had because I think I just completely camouflaged everything from myself and everybody around me by just being fairly wild. Brilliant social life, so in many respects, some of the best years of my life, in that sense.'

'...I realised that a lot of survival is just not allowing yourself to feel or have any concept of pain. Because once you recognise it, you feel it and you get damaged by it, and get brought down by it.'

'And so I was already thinking back over the past before... I got the assessment. So I went to him (GP counsellor) and he said, 'Well, tell me how you feel?' I'm not sure if I'd gone on to 'ADHD' by then. I had, but I was trying to explain where all this had come from and why I was like I was. And he just laughed, and he said, 'Yeah, but tell me how you feel.' I couldn't answer that question, I had to go away and look it up in the dictionary to think, why can't I explain how I feel? I didn't really know where to start. So I literally looked it up in the dictionary and thought, ok, no, ok. So I started to write down things that I could be feeling; so I had to develop a sense of how I felt....'

The impact of his mother's depression was something Edward felt very keenly:

'I think my entire life has been affected by my mother. ...I think I did a lot to make her life worse really, because she needed the support which I was able to give her a little bit better when I was older.'

'But I always loved her, and I wanted to help her which has been part of my emotional driving force through life.'

'So all through my life I've had these ups and downs and my mother often used to say, 'oh, I wish you would be happier'. And I didn't know what she meant because I felt happy inside. ...but I've read somewhere that there's that sort of

depression that comes in with ['ADHD'] which I can understand more easily in adult years because of the knockbacks. But I don't know if I was getting knockbacks at such at such an early age, I don't know.'

Edward had sought out and always seemed to find a friendship group that gave him a sense of belonging, whether it was his friends growing up, his work colleagues or housemates. Losing his family at the time of his divorce was devastating:

'I suffered a lot because of losing the children. ...Somebody commented once that I was a damaged person which kind of surprised us both. Because I never dreamt of ever losing them. ...I'd always imagined being a father and family life and suddenly I was a father without the family life.'

Analytical commentary

The challenge to me of being with Edward was the effort it took to follow along with his train of thought. We meandered from his reflections about his self-analysis of his childhood and early education, forward to the details of another of his business ideas he was speculating on for the future, to what he thought his current behaviours or thoughts about himself and his history might mean for him in the moment. His narrative about his past identified a self who was propelled from present moment to present moment with little or no reflective capacity. The loss of his family and occupation had brought him to a hard stop and the depression he faced had propelled him into a relationship with his subjective and affective selves. Yet even in the way he narrated his story, his self-discovery was expressed and felt very much as dispassionate intellectual apprehension rather than profoundly experienced affect.

Though his narrative seemed driven by his preoccupation with his past, Edward's perspective was heavily directed towards the future. He seemed desperate to apply the knowledge he had been acquiring about himself, his 'ADHD', his brain type, his past, to design and create a future occupationally that would have all the elements of his previous

success, but this time be crafted knowingly, no longer through serendipity. His sought-after diagnosis of 'ADHD' provided him with a clearer understanding of himself, as well as an awareness of behavioural tendencies which he had mapped onto both the successes and failures of his past.

The impact of maternal depression on child development is well documented (Fihrer et al., 2009, Letourneau et al., 2013) and Edward's adult inability to identify his own feelings, while it may have been exacerbated by the difficulties in focus and distractibility often associated with 'ADHD', might also be seen to be a dissociative coping mechanism recruited to deal with a lack of maternal attunement.

Faced with failures at school, university and contemporaneously as he tried to reconstruct himself around what he had learnt about the strengths and weaknesses which made sense to him when placed in an 'ADHD' context, Edward was helped by a resilience which was serving him well to keep him hopeful, determined and forward-thinking. Resilience is often reported to be a notable part of the 'ADHD' landscape.

At the same time, the sense I had of him was that he was intent upon freeing himself from being 'the prisoner of his own perspective'. Edward seemed to be realising that he had not been the active agent of his own thoughts, emotions and behaviours, and so was seeking the support and safety of others to supply missing stimulation, organisation and direction.

Sarah

Sarah's one interview lasted 1:13 hours.

Sarah was a 54 year old part-time teacher with a chequered work history, due to her 'ADHD'. She was the child of a military family and had had a peripatetic childhood. As the eldest daughter growing up, the burden of taking care of her siblings fell on her as her mother had suffered from quite severe mental health issues. . She was happily married with two grown daughters, one of whom had been identified with 'ADHD' in school.

Narrative

Sarah asked me to meet her for our first interview at the college where she worked part time. This was largely because she said she did not drive and it would be easier for her to meet up on a work day anyway. She was 54, full of energy, with a very approachable personality. She presented as somewhat scattered in her speech, frank in her recounting of her experience of 'ADHD'. She came across as intense, with a sense of humour and self-deprecation which felt, in hindsight, like low self-esteem laced with a whiff of desperation. Her story had a lot of trauma in it, told matter-of-factly yet in a way that clearly conveyed Sarah's sense that she had had to contend with a great deal of misunderstanding and poor treatment over the years, especially in her work environments and often vis a vis her 'ADHD' diagnosis.

Sarah ended up cancelling our second interview, citing an unexpected work issue. I subsequently checked in occasionally as the summer months ensued, not wanting to press her when she was perhaps on holidays from the academic year. Finally I concluded that I was not going to hear any more from her but sent her a closure email thanking her for her participation and the time she had already given me.

A long and thoughtful email response back to me revealed the enormous amount that had been going on internally for her since our meeting. While she had enjoyed being

listened to and being believed regarding her 'ADHD' she had found that her mood problems had resurfaced in the weeks afterwards probably due to the painful memories that had been reawakened around her telling me about losing a job she had had a few years previously. She had finally managed to get a new part-time lecturing job and the 'challenge of keeping organised when I have so much new planning and preparation and marking, never mind all the reading up on subjects I need to teach, it takes most of my focus', meant that she did not have much in the way of spare internal energy to continue with me. Sarah said that the past three years had been so hard for her that now, as life was finally on an even keel, she did not 'dare to do anything to put that at risk.'

What follows then, is Sarah's experience of 'ADHD' as told to me in our single interview. What is less elaborated on as a result is Sarah's relational experiences, though some mention is made of her childhood and current family, and the details of her life context are much sparser than that of the other participants. This perhaps reflects the immediacy of the trauma that Sarah was trying to process when we met, which I had no context for apprehending at the time, and which, in retrospect, her particular form of 'ADHD' manifestations was only serving to aggravate.

Sarah had been happily married for 32 years and had two daughters, one 30 and one 28. She believed that her younger daughter also had 'ADHD' as Sarah reported that she had a 'high need for novelty' and when she was at school. a teacher had thought she might have it as she got 'overwhelmed', drifted off in the middle of things, underperformed and, though she should have been a distinction student, was 'scraping by on passes.'

Sarah was an 'army brat' and the family had moved around a lot when she was growing up. All her school reports used to say about her that she could do better and needed to 'stop talking' in class. But unlike her brother, who 'ran around' and was always in 'fights and troubles', Sarah was never 'naughty'.

Sarah's mother was 'quite poorly' when she was about 10 and 11 years old. Sarah

remembered that her mother had woken up in the middle of the night screaming and panicking and her father tried to quiet her by putting a cushion over her mouth, so she would not wake the children. Sarah's memory in childhood was that he looked like he was trying to suffocate her. Her mother went away for weeks to Germany, Sarah figured it was to a hospital, and none of the children could visit her. Sarah had to look after her brothers and sisters. When her mother returned, she was a 'gibbering wreck' and though she used to scream and shout at all the others as well, Sarah was the one who got shouted at the most. Her father often used to tell her how emotional he thought she was and how clumsy: 'Gosh, you're like a fairy elephant when you're running around upstairs!' which Sarah wryly acknowledged to me was 'not good for your self-esteem.'

After Sarah left school she did a lot of what she called 'rubbish jobs': working in paper shops and being a dinner lady. But she always knew that she wasn't really fulfilled by those jobs. When she was working as a receptionist in the media centre of a university, she realised that she found the students interesting. She went on to work as a technician followed by a job as a media technician. Sarah found this job highly impairing due to the never-ending chaos and constantly changing demands of the role. She ended up having a breakdown. She recovered, went back to work and got through that and a teaching degree. She was a full-time teacher then for several years until the stress once again 'built up to burst.' Sarah reported that she had been on anti-depressants on and off for most of her life and had been diagnosed with a mood disorder.

During this period her father became ill and was dying of leukaemia. At work, pressure was building as classes were getting bigger, equipment was breaking down, and she was having to deal with a 'blame culture' which Sarah found difficult not to take personally. She went away to Las Vegas for her 50th birthday, but when she came back she was unable to focus on anything and had another breakdown, took three months off work and during this time received her 'ADHD' diagnosis.

Sarah kept trying to convince her employer that they needed to make some occupational

changes, like giving her a desk to aid her self-organisation and moving it to a non-distracting, less noisy space, to help prevent her having another breakdown. These requests were ignored and instead the work load was steadily increased; Sarah ended up panicking and having to go home. Despite providing documentation verifying her diagnoses of 'ADHD' and moderate depressive disorder, she was unable to persuade the institution to cut her workload down to four days and they suggested that she leave. She accused them of constructive dismissal and eventually both sides settled. That had been a couple of years prior to our interview. Sarah was currently doing a couple of part-time, temporary teaching jobs in the week with no certainty that either of those contracts would be renewed.

The chaos of internal hyperactivity: 'Even on a calm day, it (brain) never stops up there; it never stops just rattling around and around…'.

Sarah had had some training for detecting 'ADHD' when she was about to teach a group of students with autism and 'ADHD'. So she started to ask herself some questions:

> 'Why do I keep failing my driving test? And it came to possible 'ADHD'. Why do I get overwhelmed so easily, possibly 'ADHD', and I kept on making sense that it's possibly ['ADHD']. …I kept ticking all these boxes and every time…this word kept coming up all the time, and then I remembered what they said… about my daughter at school, and I mentioned it to my family, we were all around together, and my son went, 'Yeah, that sounds exactly like you!'

Sarah reported that she had always had sleep difficulties. She had quite a familiar relationship with her GP, despite the fact that he told her that 'ADHD' was not a real 'disorder':

> 'He doesn't say, you're a hypochondriac, he just says you're somebody with a – what's the word he calls it? – high health anxiety, and he might have a point,

but that's not the same as being able to do what I want, even now.'

'Because my brain was just going round and round and round and that's the bit I managed to get my GP to understand. I said... there is nothing in here (pointing to her head) that I can go switch this off, and it just keeps running around and then I physically stop, turning over and over in bed, moving, getting up, getting down, going to the toilet all the time when I don't need to go to the toilet and I just cannot turn it off. But the trazadone [prescribed for sleep difficulties] really helps. ...If it's a strong enough dose. And then I can't get up in the morning, so that's why it takes me two hours to get going.'

'I've been down so many times, and I keep saying to my GP when I keep going on about my weight, I do keep trying. I never give up. I never give up. Sometimes I feel like giving up and sometimes I have a moment or a bad day, but I still get back up.'

When she was diagnosed and put on a low dose of methylphenidate Sarah said that:

'.... it's like somebody had pulled up the blinds. Oh my God! I'm awake! And that's what it felt like.'

But she had to stop the stimulant medication after a few years because she had high blood pressure. The other effect of medication that she disliked was that it stopped her daydreaming:

'I can't have empty space in my head, but I could invent all sorts of stuff, like a story, but I could never write it down. .... Nothing goes wrong in your daydreams. When George Clooney is just about to rescue me from whatever, everything goes my way.'

One of the most impairing things that Sarah had to deal with was not being able to pass

her driving test:

> 'I have to focus really hard on changing gear. And I never get it right. And I think it's because if I have to focus on anything, what follows afterwards is the bit that goes wrong. …Because when I have to think about down, across… I need my left hand. With your left hand and your feet, …your whole attention is on that, and you lose the capacity to hold all of those things you need to hold in order to be safe…. And under pressure of this test.'

Trying to fill out forms is a challenge:

> 'Just like I'm looking at everything from behind a pane of glass. It's kind of frozen. Paralysis almost, really. It's like I'm trying to do it and then all of a sudden it happens. And I think, oh, that wasn't so bad! …one of the things that does help is having some other noise like TV or music. Music really helps…. Just to have something that will actually stimulate me to do something else.'

Even getting dressed is a major focus and decision set of challenges:

> 'I'm wearing a pair of socks today just because they're new. In a week I will never be able to find both of them. I have a bag, this big [indicating the size of the bag with her outstretched arms], of socks that come out of the washing machine. And at some point, if I have a moment where I can concentrate, they all end up going in there. I'll find something that's similar, and at some point, I'll just chuck them all away and just go and buy new socks. Because it's just too boring to find your socks.'

> 'I never wear dresses anymore because just trying to get dressed with tights and a skirt and a top, it's just too hard. I don't know why I can't make it happen.'

> 'To get dressed and remembering to make sandwiches or not to make

sandwiches. It's ages since I stopped bothering making my lunch because I just can't get all the stuff together, and the dog, and all the stuff I had to bring with me because I don't have a desk to leave it on anymore. ...And other people seem to be able to manage it and I just don't.'

Sarah's feels quite victimised by her experience of the non-stop, involuntary quality of her constantly racing thoughts:

'But even on a calm day, it never stops up there (pointing to her head). It never stops just rattling around and round and some random thought about gold paper and then ten seconds later I'm thinking about couscous: How do they make couscous? I want to know how that happens? Gold spray paint? Why and what... and then I think to myself, why do those two thoughts even come together in my head? It's an abstract conversation I'm having with myself, or some person that I used to see, and quite often, I think, since the last breakdown. I question everything I do. Why did you put your left shoe on first? Why didn't you put the right shoe on first? And it never stops and that would be something I'd give a lot of money to get rid of.'

'I don't want to be thinking about that at four in the morning or when I'm in the shower or, you know, like total garbage. It's like some spaghetti just going round and round and none of it is any use.'

'ADHD is not a disability like being in a wheelchair; the disability impairs you from being your best self.'

What Sarah experiences because of 'ADHD' compromises her sense of self:

'I just can't, on my days off, find the will to do anything and I find that distressing to feel this. ...I feel lazy. I know I need to just not do anything for a little while, but then I feel like my life is wasting away and I feel lazy.'

'So I do understand when people say it's a disability. It's not a disability like being in a wheelchair. The disability impairs you from being your best self.'

The disconnect between how Sarah experiences herself and how the world perceives her is confusing, shaming and demoralising:

'And I shifted all my lessons around...so I don't have to do anything, and I can just be quiet and that helps me to think, and it just gives me a kind of a sense of detachment and I don't get overinvolved in everything as well. Like, you know, they used to say to me, "Oh, you get overinvolved in everything and you just care too much about everything and you can never just do moderation. Why can't you just be quiet and calm?" [Laughs]. I'm thinking, who is this person that they're talking about? I thought I was just passionate and caring. Talking about me is like a nightmare because they said, "When you're brilliant, you're brilliant but when you're not, you're a nightmare." What? Who is this person that you're talking about?

The not being able to rely on herself is directly correlated with her challenged self-esteem:

'And you just end up bashing yourself over the head and every time you say maybe I haven't got it, maybe I've got on top of it and then you realise, well, I've lost a book from a month ago that's got a student's piece of work in it and then you feel like crap again because you know and then you feel like saying, no it doesn't and people say to me, well, if you say you've got it and you say it doesn't affect you but....and you are in charge but you're obviously....I'm obviously not totally in charge.

Not having agency impairs her sense of self:

'And I say.... I wish I could.... I wish I wasn't like that. I wouldn't want to be it,

you know? I wouldn't say I love it. I have this thing and then I'm not proud of it. I'm not proud of it. I just wish it would go away and I could just for once before I get to 60 maybe [laughs] just feel I'm in charge.'

Painting is where Sarah can disconnect from her mind, focus and moves into a rhythm that seems to match her internal environment:

'I felt calm and when I was in the middle of it…. because it's just abstract shape and colour and form. It doesn't have to be for anybody else. And I was just…. I was totally focused. I mean…. the dog was going crazy and I just lost…. I just put him somewhere else and I felt completely at peace. …. And there is no thinking. There's no, okay I was subjective here. This all, oh, and I'll stick that bit there and flick this brush, and what if I did that with my hands… and it doesn't matter what it comes out like.'

There is a defiant and self-affirming part to Sarah. For her 54th birthday she got drunk and, amazing her daughter, got herself a tattoo that simply says: 'I am enough':

'It's just an affirmation for me for all those people who said you need to change, I don't. I am enough.'

Analytical commentary

Sarah's narrative felt balanced between the past and the future, as she struggled to make her life in the present work for her, based on a growing acceptance of herself and what she needs. Her priorities in making her life work are about attending to earning money for her family, meeting her occupational demands, and taking enough care of herself so she can do that.

Perhaps the greatest tension that was highlighted was that, at the same time she was holding a running commentary internally with herself about what she ought to be doing

from moment to moment, she felt driven by forces that she was unable to control. She was able to exert some agency sometimes, but this required an enormous effort of concentration, focus and decision-making power that drained her to the point of complete exhaustion by the time the task was over. This tension was duplicated externally in her repeated and failed efforts to have her work world pay attention to accommodating her needs so that she could have a chance of following through on her own best and clearly very capable intentions.

Sarah's early development was marked by attachment ruptures as well as geographic ones. The story of her mother's breakdown begged the question as to whether Sarah, the child expected to take care of her siblings and constantly criticised for not doing it right, became what Johnson calls 'the used child' (Johnson, 1994). Sarah grew up with all the characteristics Johnson describes: '…extremely sensitive to slight or criticism, prone to depression and hypochondria, bothered by thoughts of worthlessness, imperfections, etc.' (1994, p. 172).

While it feels as if the intensity of Sarah's affect, her dependence on her GP for support and validation despite his dismissal of her own self-assessed 'ADHD', and the breadth of her impaired self-esteem point to associations with early developmental trauma, her mind-racing, fatigue, daydreaming, and huge difficulty in focus-switching all indicate associations with an 'ADHD' profile.

Heidi

The three interviews with Heidi lasted for 1:8, 1:9 and 1:0 hours respectively.

Heidi was a 48 year old Director of Nursing for a family-run private nursing home. She had two school-age children. Her son's 'ADHD' diagnosis through a school referral had led to her own. She had divorced her alcoholic husband in her country of origin many years previously and had moved to the UK. She was in a long term relationship though she and her partner did not live together.

Narrative

Heidi was referred to me by the facilitator of the local 'ADHD' self-help group. My interest was piqued by the facilitator's email giving me Heidi's contact details, as she said that she thought Heidi was 'a lovely and lively lady and I think quite different from some of the other interviewees you've met.' I wondered what that meant to the facilitator. We met for the first two interviews in Heidi's home, though she had wanted the second to be at her work. I got the impression that Heidi's professional identity was something she wanted to be noticed. We did end up meeting at the nursing home where she was the director of nursing for the third and final interview.

Heidi presented as a physically compact, youthful, middle-aged woman. She had an accent, possibly Nordic, clearly not British in origin. I did not probe for her birth country and Heidi never chose to volunteer it. Her English was excellent, and her occasional creative versions of idioms seemed more an expression of who she was than a problem with language fluency. She reminded me of a French-Canadian friend who used to describe someone who was angry as 'flying off the wing'. You'd get what Heidi meant, and the verbal intent was contextually appropriate, but the idiomatic usage was just a bit, endearingly, off.

Heidi spoke about quite traumatic experiences and events over the course of her life with a concreteness that belied the gravity of what she was describing. My efforts to gently dig

deeper into her affectual experience were not rewarded. Where affect did rise to the surface it seemed to be associated with 'ADHD' issues such as boredom, difficulty sustaining attention with me, or the struggle to maintain awakeness. I was conscious that an air of dismissiveness and a feeling of being in the presence of a 'caged lioness' crept in towards the end of the third interview which I interpreted as Heidi having had enough of sitting still, talking to me. Heidi had the intriguing quality of appearing vigourously self-trusting while at the same time being aware that a low level of self-esteem had dogged her emotional development. It was this paradoxical quality that I think the facilitator was struck by.

Heidi was a single mother of two children: a son aged 17, and a daughter of 14. Her son had been signposted at school for an 'ADHD' diagnosis when he was 12. Encouraged by her son's mental health team, this led to Heidi's discovery and diagnosis, at 42, that she was the genetic 'ADHD' parent. Heidi was 48 at the time of our interviews.

Much of Heidi's relational world was focused on her mothering. She had been through a long journey of trying to find out what was going on with her son, and how best to help him. When he was 1 ½ she reported that a 'switch flicked' and he turned into this 'raving, lunatic child that was bouncing around the house.' Yet he soon spoke two languages, was reading books and retaining an incredible amount of information. He had trouble sleeping, would be awake from 2am, and took no naps during the day. Heidi had a hard time keeping up with him, going out every day to give him wide open spaces to run around in, taking him to toddler gym and swimming classes trying to wear him out.

At school, Heidi knew something wasn't right, but was sent to parenting courses, the assumption being that her son's behaviour resulted from poor parental skills. Heidi went, but knew in her guts that this was not the problem. Her daughter had the same mother yet had none of the same issues as her son. None of the medical and educational professionals threw any light on things over the years until someone at her son's school suggested he be referred to PCAMHS for 'ADHD' testing when he was 12.

Heidi was dispassionate when she talked about what she saw as her own dysfunctional upbringing: 'I wasn't a wanted child in the first place.' Her mother was 16 when she got pregnant and Heidi reported that she got her 'ADHD' from her father who was absent in her developmental years, having left the family when Heidi was four. Her mother told her that her father was impulsive and never achieved anything. He 'drove like a lunatic', had various car crashes, and went in and out of jobs. Heidi's conclusion was that he had 'destroyed his life'. From an early age then, Heidi was sent to stay now with one grandmother, now with the other, as her mother worked every day and often on weekends. Her mother was always tired, and Heidi had to stay in her room until she was a certain age, and then was expected to go and play out of the house.

In her last year of school Heidi realised she was fascinated by biology, and so decided to become a nurse. Her mother told her she was 'too dumb'. No one else in her family had gone to university. She was able to focus on the grades she would need to go to nursing school and got in, albeit with the bare minimum.

Heidi gave up her career when she had her children and was not planning to return to work. Everything was 'rosy' in her world until her husband 'became an alcoholic.' She ended up insisting he move out as he was not safe with her or their children. Heidi had to go back to work. When his alcoholism eventually killed him, because she had separated from him, Heidi had no legal claim to his pension or any government benefits. Because she had not worked for several years herself her own pension was compromised, and she had to start from the bottom of the job ladder again.

Heidi found that her nursing skills were best applied when there was a high level of contextual stimulation. She was fired from one nursing job because she did not have the patience to cater to the demands of an elderly patient who was insistent that her hot chocolate be delivered to her during a power outage and Heidi did not see this as a nursing priority. She ended up going back to university to do a degree in critical care nursing – a very specialised job for which she felt she was ideally suited.

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When her son was 12 she and her two children returned to live locally as her son's schooling had not been right for him as he was clearly failing. Heidi herself had found another occupational niche that worked well for her – nursing director for a privately-run care facility.

'I was just a really, really naughty child according to everybody else' – the misperception of behaviours.

When Heidi looked back from the vantage point of an 'ADHD' explanation for her behaviour growing up, she could readily see some of the common 'ADHD' characteristics:

At school:

> 'It's such a vivid memory, constantly being distracted by patterns, by noises, by somebody coughing and I'm off on one. And then I'd lost the plot with what was happening at the front of the class, and then once I'd lost the plot, I thought there's no point now trying to catch up because I don't…. understand it. So my grades were really poor. Really, really poor.'

At home as a child, which was a block of flats with storage cellars in the basement:

> 'I did get into trouble a lot then. I remember one episode where I was actually arrested, aged 8 or 9, because I was bored. I was really, really bored. I had nothing to do, nobody to play with. …. [I had] …just broken open all the locks [of the cellars] and tidied everything up ….and structured it, every item in alphabetical order. I put everything beginning with B…: so bikes, boxes, into that cellar. …And or course I got caught. I mean I hadn't stolen anything. I tidied up everybody's cellar, but adults didn't see it that way. …. somebody called the police and I got done for burglary age eight. Until this day she [mother] talks about how naughty I was as a child and how appallingly behaved I was. I don't see it that way. …. But you know, who listens to an eight-year-old child? …I was

tidying up. My mum always told me to tidy up.'

In nursing school:

'I do remember having to reread pages and I think, maybe looking back, I think that was another symptom that at the time I didn't realise. Now I can take medication and that goes away.'

In the workplace:

'And then the other thing that struck me when I started taking my medication, my desk is utter chaos. I had piles, really big piles all over my desk and a bit like my bedroom when I was a kid. I knew where everything is, I knew every document, what had to be in on what date, it was all in my brain. But to any other person, my office was just chaos.'

'I'm constantly distracted by the things around me. And then I start fidgeting, my feet go tap, tap, tap, tap, tap. It's very difficult. Sometimes I can manage it by standing up and standing myself literally in the corner, because then I can tap, or jiggle, or throw balls around.'

Medication has helped with focus and organisation:

'It's almost like it slows me down. It's almost like a slowing down feeling. Because I can tell when it suddenly kicks in, it's almost like a switch, I can feel it and I can just really focus and really concentrate on something that I'm doing.'

Sleep is a big problem:

'... it typically happens at 3:00 in the morning when the first thoughts come in and they wake me up. They stop me from sleeping because it's such an urgent pressing thought like, oh my god, you need to pay this bill, you're being arrested

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today for a non-payment of electricity or something, and it becomes such a panic that it wakes me up. And then comes the next thought, have I done this? Have I done that? I need to do this. Oh, I must remind by myself to write this letter, and I'd go from one thought to another, buzz, buzz, buzz, buzz, and that all about, must do, must do, must do, must check.'

This state of mind is not something Heidi identifies with as anxiety, which is a different experience for her. She knows when she is worried or anxious – this state is 'just my brain being really active.'

Feeling too much: 'I'm just too large for life, too big, too bubbly, too bouncy; how's anybody going to catch me?'

Even though as a child Heidi felt that everyone saw her as naughty, her recollection of herself was as someone whose intentions were good:

'I tried to please. I tried to do as I was told. It just always ended up in the wrong way. It just didn't work out. It was always assumed that I did that on purpose, with malice, and I didn't …so on a daily basis, I used to let myself down.'

'And it confirmed what my mum said, 'You're dumb, you're useless, you're not worth anything. You're never going to achieve anything in life.'

Heidi felt keenly the stigma attached to her diagnosis of 'ADHD', something even more burdensome given her history:

'I don't want a stigma. All my life I had: 'Oh, here she comes, Trouble!' from my mother. And I wanted to move away from that, I didn't like that. I wanted to be the good person for once in my life, not the bad person.'

'And I think it's made me into this resilient, ambitious person, because I would

prove her wrong, one way or the other. And I have, and I did.'

'I became a nurse and I had absolutely set my heart on that. I will not be told
I'm too dumb, I'm too this, I'm too that. I w*ill* do this! ... . And now I'm a
director of nursing. So I've made it, I've achieved that, I've worked hard for it.'

Heidi has learnt from bitter experience that her intentions are often misperceived by the
world because she has 'no brakes'. She defends against this in two ways:

'I can just prewarn people, I suppose, to say that, "If I do upset you one way or
another then, please be patient with me and please alert me to the fact I have
upset you because I may not realise it and I might say something that to me
makes sense that you might misunderstand." So, I think that's the best I can do.'

'And because of the ADHD, I do still think today my life is over, tomorrow my
life is over. It will finish. I need to enjoy today because tomorrow it will be gone.'

For her 'ADHD' is a very isolating experience:

'But what people don't see is the struggle behind the façade. And I think the
chaos in my brain, people have no idea what it feels like in how disorientating it
can be and how hard it is to concentrate.'

Not being able to focus may stem from a neurobiological source, but by the time Heidi
hit adulthood there were many emotionally traumatic layers that had become associated
with it, triggering the self-critical voices within:

'I think it's based on inadequacy. I think the underlying feeling is always the
lack of not achieving, not being good enough, not doing it the right way because
when I work, I work in a way that is different to the rest of how society works.
And so I always think, I stick out, I do it in a different way, and so it must be
wrong. So there's always that feeling of inadequacy, that feeling of not being

good enough because if I don't...if I have three reports going at the same time and people just see chaos, they've already judged me, they're already like, "Oh my god, this will be interesting to see, you know, what's coming out of this one." The end result is usually people go, "Wow! Brilliant report." And that is amazing. The things you've come out with are just rea-... "Oh my god, can I copy this?" you know. So, I do always get the reward at the end, but throughout the journey of producing the reports I have this feeling of not quite good enough, not achieving, not doing well enough.'

Analytical commentary

Heidi seemed to have been one of those children for whom resilience – a good outcome in spite of serious threats to adaptation or development (Masten, 2001) - was an ameliorating factor in how she overcame the early developmental trauma she experienced – an absent father, a dismissive mother. A teacher was an early mirroring figure, in the Kohutian sense, who believed in her and broke academic tasks down into learnable pieces for her, exposing her to the capacity for mastery. This gave her a sense of what she could do and we know that 'Efficacy expectations determine how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences' (Bandura, 1977) as represented by her emotional environment and 'ADHD' symptomology.

Heidi was very clear that she had spent virtually all her adult life trying to negate the internal critical parent she carried around with her who told her she was inadequate and incapable of achievement. Yet something in her temperament and personality, as well as a brain driven by need for stimulation, kept her moving forwards and allowed her to hang on and be guided by her conviction that, despite the world mirroring her back in a way that was at complete odds with her intention, she herself knew she meant to do good, and did not mean to do ill. This kept her centred and grounded.

Another protective factor appears to be the attachment Heidi has to her children. She

alluded to how she had been through challenges like smoking 40 cigarettes a day, a series of broken relationships, an eating disorder, suicidal ideation, as well as drinking too much to cope with the pain. What stopped her relationship with self-sabotage was receiving the love that she craved: 'that little thing to love and nurture and hang on to… to get somebody who loves me back. That sort of robbed me of my chance to self-harm and self-destruct.'

Heidi had come to an acceptance of the qualities of her 'ADHD' symptoms over which she could exert some strategic control. She used her phone to keep herself organised and take her medications. She chose her occupational environment to suit her relational and 'ADHD' needs. She declared her 'ADHD' as a disability and was transparent with colleagues about which of her behaviours were to be interpreted through that prism first in order to manage expectations. The price Heidi seemed to continue to be paying, though that was being slowly modified by a new, stable relationship in her life, was the fear of interpersonal trust and vulnerability.

My sense of Heidi was that she lived very much in the present, despite the shadow of her mother that was a constant presence. The intensity of her brain activity, her need to always be on the go and active in some way or another, almost made that feel like a foregone conclusion. Her defences felt impermeable and inaccessible, especially to herself, and might, I suspect, present quite a challenge in the therapeutic sphere.

Huw

The three interviews with Huw lasted 1.17, 1.23 and 1.33 hours respectively.

Huw was a 58 year old retiree, a hoarder, and since he had found the courage to declare his diagnosed 'ADHD', survived on disability benefits. It was important for Huw to 'give back' as a result and he did this by volunteering in his community and training as a volunteer docent for a large art gallery. He had had a difficult familial, academic and professional history and in his early adulthood had been an alcoholic. He had been sober for more than 18 years and attended AA regularly. He had not been in a relationship for a long time.

Narrative

Huw contacted me via the Online Learning site, which had been set up to serve patients who had been diagnosed with 'ADHD'. Huw told me in the series of emails we exchanged before we met that he had been diagnosed four years previously, when he was 54. He wrote that he took medication for 'ADHD' and regularly attended adult 'ADHD' support groups. His emails were to the point and mostly utilitarian. He initially suggested we meet in a café in central London, but I demurred on the grounds of wanting a tranquil space to talk and a concern for his confidentiality. We agreed that he would come to the institute where I have my counselling practice. I made a choice to use a different room from where I see counselling clients to help to keep my researcher and clinician selves more boundaried.

Huw was a tall, rangy man, looking younger than his 58 years, with a deep, rumbling – what he characterised as a 'booming' – voice. His hair was longish and his face open, and he often smiled in self-deprecation. He sometimes had a tendency to ramble, and once I heard his story I wondered how much his early history of alcoholism, as well as his 'ADHD', played a part in this.

From early on in Huw's narrative, he talked about how he had drunk heavily in his teens and early 20s. He characterised this as a 'disastrous way of trying to cope with' unbearable feelings. He was familiar with counselling, having had several different exposures to different

modalities: Cognitive Behavioural Therapy (CBT), Compassion Focused Therapy, and his understanding of himself and the language he used reflected his psychological mindedness. He had quit drinking 18 years previously and was still a regular Alcoholics Anonymous attender. This seemed to serve just as much to connect him socially, give him a place to belong, as a means to remain alcohol abstinent.

Huw's father died aged 56, when Huw was six; his mother was 52 and Huw 19 when she passed away. He had two much older sisters and Huw believed that the eldest was autistic or at the very least 'on the spectrum'; both sisters were talented artists. Huw felt that his sisters had a much more stable upbringing than he did until they were in their mid-teens, with lots of grandparents, uncles and aunts around, as well as their parents. However after his father died he reported that he 'had my mother to myself' for a couple of years until she got romantically involved with a local GP at the practice where she worked. His mother and her new partner became addicted to drugs and then alcohol, so Huw's mother 'wasn't able to mother me' and life became exceedingly insecure and precarious.

Huw went through a period of going to lots and lots of different schools but, as he was always the biggest and tallest, he avoided being bullied. When he was about 13 he refused to go to his school anymore as he felt the level of education there was so bad and ran away from home. His sister ended up rescuing him from some stranger's floor as his mother 'had gone off somewhere'. He enrolled in a school local to his sister but fared no better and started labouring on building sites. His sister told the local authority and he was sent to a boarding school out of London for 3 years. He felt well supported there and got through his O levels. He was on his way to doing his A levels but was drinking in the holidays and started to fall apart. He ended up being expelled just before he turned 18.

One of the masters at the school had quit to start an outdoor education business and Huw went to work for him for a while. Looking back Huw reported that he was supported, but also exploited, by this man. He characterised this period as the 'difficult years of my drinking'. It took him ages to get his A levels but eventually he got some. He then went to

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university and did a computer programming course.

Huw got hired by a large computer firm and though he suffered a number of nervous breakdowns, he progressed in his computer career. He did not feel as if he belonged in the world of corporations and money, so when he was offered voluntary redundancy, he took it. He then retrained as an actor, which he did half-heartedly on a part time basis and made little money from it. Signing on the dole was not good for him as he felt as if he was in an atmosphere of decay. So he volunteered at a museum and trained as a guide. Declaring his 'ADHD' as a disability qualified him for benefits. This meant that he was able to get by.

Huw has had no serious relationship in the last 20 years save for a brief love affair 18 years ago when he was 13 years sober. He had one AA sponsor who took him under his wing and with whom he lived for many years. This man's kindness and attention gave him enough structure to learn how to stop his nihilistic drinking and learn how to stay sober. He inherited this friend's flat upon his death where he still lived. Huw had been sober for 33 years.

The nuances of the need for stimulation: 'I…cope with…an extreme of something. I almost need an extreme of something. Moderation is difficult for me.'

Huw was a hoarder and it was when acting in a play about an elderly hoarder that someone suggested he get in touch with a hoarder's group. Some of those members were going to a psychiatrist's lecture on 'ADHD' and Huw identified fully with the symptoms as described. He went to his GP and pushed for a referral to get diagnosed.

Huw said he found it hard to track conversations as his mind flitted in other directions and he would forget the topic of conversation: 'I will try and remember things or assume I will remember things, and I don't.' He had difficulty too in following due process in a task, and was unable to read a book from cover to cover. He used his phone to try and keep organised and google sheets as a reminder function to do things like take his medications on time. Creating general to-do lists helped keep himself on track.

In school Huw got the constant message that he was underachieving. He was always late and remembered constantly trying to think up excuses to explain why. Even now he usually arrives too early as a way of compensating, but always had the sense that he was and would be unreliable. He was constantly fearful of forgetting things: the right props when on stage or the right paperwork for his guide work.

While Huw acknowledged that sleep is supposed to help 'ADHD', he found that he was extremely sluggish when he woke up and for much of the day: 'Most people are feeling tired when they go to bed. I'm just starting to come alive.'

Interpersonally Huw had observed of himself that he seemed to miss cues:

> Because I can sense emotion, you know, generally. I can sense lots of things. I can definitely sense if there's anger or fear or sadness or joy. But it's kind of like interaction-type cues maybe I miss.'

'I always think I'm not reliable' – the insecurity of self.

For the previous thirty years, Huw had told himself that all the difficulties he experienced were accounted for by the neglect he had experienced in his childhood and his abuse of alcohol. Being diagnosed with 'ADHD' relieved something in him:

> 'I'm looking at myself in a completely different way than how I looked at me before. There's nothing, no effort I could make, no extra thing I can do if I tried hard enough, to change some of the things about me. And that's quite a shock.'

> 'I didn't have to take responsibility for becoming something that I couldn't become, which is what I'd been trying to do for most of my life.'

Huw also felt that the childhood neglect accounted for why he had very low poor self-confidence and would always defer to those who had more strongly stated views. But

he wanted to see some positives in having 'ADHD':

> 'ADHD can be quite a good thing to have if you're in the right circumstances. If you've got a good supporting network and you're doing the right job, it can be a wonderful gift. But if you haven't got those things, it's hard to get them. And then, it's a hobble. You know, it's a handicap.'

He had a yearning to be more connected with people but noticed in interactions that he would get bored, or go off and do something else:

> 'So something I might be learning by staying with you, and being present to our communication, doesn't happen and I'm off thinking about something else and pretending to be there. I've got to make it look as if I've been here all the time.'

This sense of pretending meant that Huw had spent much of his life feeling like a fraud:

> 'My acting is more of an alibi than a career. I can hide my disability behind acting. The reason why I'm not working is because it's very difficult to get work as an actor. And the reason why I'm so eccentric is because I'm an actor – all actors are eccentric. And you know, all sorts of things can be excused.'

> 'Believing it [his 'ADHD' as a disability] has taken a long time. Well, it's just very convenient, isn't it? Am I just making this up so that I can be lazy, you know?'

> 'I'm thinking, 'I'm a scrounger, you know, giving myself a hard time thinking about it. But I've come to terms with that. You know, having a disability really helps with that.'

Huw feels that self-growth had eluded him:

'I've been in a kind of coping, surviving mode, rather than, you know, growing and achieving.'

Analytical commentary

Huw lived in a worried future of catastrophic thinking and self-doubt. This could be alleviated by getting out of his flat, being with others and in nature. The damage to his self-image, self-esteem and self-worth were significant. His own estimate of causative agents was firmly aligned in his mind with family neglect and the family injunctions that applauded excessive drinking that were a part of his growing up. Many adults with ADHD feel like imposters and struggle to hide their inadequacies from family and co-workers (Nadeau, 2002). Research suggests that individuals who have an insecure attachment style endorse feelings of the imposter phenomenon and also have experienced more fear of rejection or abandonment in intimate relationships, thus feeling unstable and possibly unworthy (Alvarado, 2015).

Huw's hoarding feeds into this profile of developmental trauma and attachment challenges as hoarders report a significantly greater number of different types of trauma, more frequent traumatic experiences and problems with emotional attachments (Hartl et al., 2005). The inattentive symptoms of 'ADHD', rather than the more commonly associated OCD, significantly predict severity of clutter, difficulty discarding and acquiring (Tolin and Villavicencio, 2011).

Huw's participation in the research process was his way of making up for the deficits that dogged his sense of failure and inadequacy. He was 'giving back' the best way he could to make up for being a 'scrounger', taking something for nothing from the state as a declared disabled person. The relief this brought was enormous – he no longer had to 'try harder' somehow. Yet the future seemed short and the challenge to find purpose and relationship, given his occupational and social impairments, sometimes too overwhelming, sending him into a dark place of suicidal ideation. He craved connection but despaired quietly of having

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the tools to manage relationship in any sustained way.

Analytical commentary summary

The invisible compromise to the self

Part of the problem the individuals in this study faced was that they were trying to cope with the consequences of neurobiological differences which were not visible to others. This resulted in the disbelief of family, friends and others and the experiences of stigma and shame. All the participants experienced this to one extent or another. When we look at the interpersonal consequences of this, we hear that, from an early age, the manifested differences of these individuals were often misinterpreted and experienced by others as annoying, deliberately dismissive, or negatively intentional, when they were not. This caused tremendous cognitive dissonance and emotional trauma which resulted in heightened feelings of aloneness and loneliness. Who they appeared to be to others is not who they felt themselves to be internally. This set up an enormous conflict between their subjective and objective selves. When Huw finally chose to declare his 'ADHD' as a disability – already something of a shaming label for him – his subjective negative experience of himself was alleviated, allowing for change: 'It's really good to have people around who really do accept it and know it. It's nice to be made allowance for, not dismissed.'

The fragmenting effects of disbelief

'When participants are known intimately as people, not merely as categorical representatives, categories fragment.' (Clandinin and Connelly, 2000). As therapists we aim to get behind the categories, the labels (diagnostic or otherwise), the stigma, the biases, the assumptions that have been made about a person, in order to meet them in a place where they can 'feel felt' - Siegel's term for the attunement of states between two people which forms the non-verbal basis of contingent collaborative communication (1999).

Another common experience that participants contended with was not really being listened to within the medical system. One participant was told by their GP that 'ADHD' did not exist; another took it upon themselves to educate their GP about the condition while another campaigned their local Clinical Commissioning Group to pay for and add the medications licensed in the UK for the treatment of 'ADHD', so they could be accessible for their GP to prescribe. Joe and Edward fought the NHS system for a number of years to pursue and get a diagnosis and treatment. Sue preferred to keep her working relationship with her GP intact, rather than push harder for treatment in the face of his disbelief in the condition. Heidi had to overcome her own fears around the condition to avail of treatment that ended up helping her manage her job much better. In many cases it took years to get from GP referral, through assessment and diagnosis, and finally to trying medication – the first line of treatment according to NICE guidelines (2008). Even then medications sometimes did not work or had too many side effects to be considered efficacious. Clients' inner experience of this was stressful, depressing and added to an already low sense of self-esteem.

Participants' experience of being a 'patient' was of struggling to articulate the inner effects of the impact of their outer behaviours. Often what was elicited from professionals was a reduction to medical categorisation: what you are experiencing is depression; your symptoms mean you have anxiety; you may have a personality 'disorder'; you need medication to help you sleep. The parts were being attended to, but the participants felt that something more holistic about their experience was being missed.

Of the six participants, four essentially diagnosed themselves. They came to a new, more meaningful understanding of themselves by their dogged hunt over a considerable period of time to find the right words to put around what they were experiencing. Eventually, the descriptions of 'ADHD' made sense of themselves in ways that nothing else had up until that point in their lives. Heidi and Sarah came to this new prism of self-perception through the diagnosis of one of their children. Their tenacity in trusting their own instincts until the right

explanation was found speaks to a need for meaning-making that feels deeply human. As Frankl so poignantly pointed out: 'In some ways suffering ceases to be suffering at the moment it finds a meaning.' (1985).

Discussion

As a integrative psychotherapist, the purpose of this study was to give a voice to the experience of adults who identified with 'ADHD'. 'ADHD' as it is currently defined is a remarkably heterogenous condition. As has been shown from participant accounts, the predominant 'ADHD' symptoms of inattention, hyperactivity and impulsiveness can be very differently felt experiences from individual to individual. Integrative psychotherapy is well suited to meeting the needs of these clients, holding as it does an interest in holding ambiguities and different starting points and an awareness of a continuing need for clinical judgement as well as therapist/client interaction in the understanding and management of presenting issues (Gilbert and Orlans, 2011). A secondary aim based on the findings of the study was to provide therapeutic guidelines to clinicians working with such individuals.

Negative consequences of 'ADHD': anxiety and depression

All the participants experienced anxiety and depression at different points through their life span. The literature refers to anxiety and depression in the 'ADHD' adult as 'co-morbid' conditions as if they are separate, if somewhat related, conditions . My understanding of these conditions is that they are symptoms of the self's unease with itself, a discomfort with being in one's own skin because the self is not integrated appropriately. Given their traumatic histories, it would not be wrong to assume that the seeds for participants' depression and anxiety flow from developmental trauma. Yet this study shows that some of the participants, however, had a strong sense that something else was going on in themselves to account for how they felt that was not answered by the normal understanding and descriptions of anxiety and depression. Edward's experience is not atypical: 'Because depression didn't answer the question of why I just couldn't move forward. I just seemed to be blocked.'

The difference was narrated in two ways: biologically as a driven, brain-in-overdrive quality that accounted for an internal hyperactivity that they could not control or get away

from even in sleep which qualified and augmented the traditional descriptions of anxiety. And secondly, as a conviction that there was a nameless something that felt 'wrong' inside themselves. The disbelief and often ignorance about 'ADHD' they had to deal with from others challenged this self-knowledge, forcing them to question their own legitimacy. This had profound consequences on their belief that they were reliable, 'normal' or worthy and necessitated living with a fractured sense of self that was unbearable enough to manifest as depression.

Herman's words about depression in trauma feel aptly descriptive of the 'ADHD' experience: 'Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder' (1992: p. 118). The particular kind of anxiety and depression in 'ADHD' brings with them a sense of falling apart, a loss of self-coherence, a traumatising overstimulation or, conversely, a state of highly aversive under-stimulation which characterise what Mollon called 'the myriad terrors and dysphorias of the disintegrating self' (2015: p. 10). Huw spoke about how he would not notice what his body was doing in moments of anxiety and had a dread of 'being trapped behind my own barriers but not having the self-esteem to get around them.' If Heidi had not had her children, she 'wouldn't have had a point of being.' And Harry came to the point of breakdown when he realised: 'Here's the work I should be able to do. I can't. I don't know why I can't do it. Like I have just no answers.'

How trauma can augment the effects of 'ADHD'

There are many layers of emotional defences that have been erected to protect and help individuals survive the vicissitudes of life, the emotional geographies of which are revealed and explored in the therapy room. The inner life of the person with 'ADHD' may be further compromised by a constellation of additional and involuntary layers of neurobiological determinants which contribute to the confusion, meaninglessness and stress of trying to be 'normal' In what feels like an abnormal world.

How complex the interplay of these myriad forces upon the individual's experience of the self is was brought home to me in the very first interview I did with Joe for this project. Joe was open, transparent, in touch with his feelings, wept freely, mourned his losses, and was candid about his jealousy of his children's chance to have the education he felt he had missed out on. He strove to tell me all he could about his experience of 'ADHD' and shared his darkest moments and the confusion he felt as he reflected on the core formative relationship with an older man he had been thrust into willingly as a child but only in adulthood had recognised its sexually exploitive qualities. His embrace of intersubjectivity was exemplary. I left reeling with what he had left me holding.

I remember calling a colleague to try to process some of what I was feeling. The clearest challenge I felt I faced was in thinking how on earth could I, for this piece of work I was embarking on, separate Joe's life from his 'ADHD'? He *was* his 'ADHD' and his 'ADHD' was *him*. The same challenge, I think, faced me as the mother of a son with 'ADHD'. To reduce my son's motivations, behaviours, desires, failures or successes to within the narrow and clinical guardrails of an 'ADHD diagnosis' was to deny the potential for a sense of self open to change, repair and reframing.

The participants themselves were very aware that who they were was something different from the impact that 'ADHD' had on them, even though they also acknowledged that the meaning of 'ADHD' to them was that it explained their behaviours and responses in ways that lifted them out of an internal self-character that was morally repugnant and returned them to a benign attachment to themselves as well as restored some of their own sense of innate goodness to them.

How stigma affects the perception of 'ADHD'

Participants in this study were very aware of and uncomfortable with the stigma attached to the descriptor 'ADHD'. Joe and Harry felt that the words d(Rowland et al., 2002)id not accurately reflect the condition as they experienced it, and Edward felt that the name was

hard to understand.

The earliest descriptions of the condition were applied to children, gave it pathology-oriented names, and there was a noted absence of any understanding that an adult could experience the effects of 'ADHD' in similar and different ways (Rowland et al., 2002) . Current language is not doing much better. The term 'Attention Deficit Hyperactivity Disorder' continues the pathologisation of the condition, stigmatising those who are given this diagnostic label (Mueller et al., 2012, Lebowitz, 2016).

At this point it may be well to remind ourselves of Laura Tisoncik, diagnosed with autism, who launched what appeared to be an official website in 1998 dedicated to the *Study of the Neurologically Typical*. The description for this 'condition' was as follows:

> 'Neurotypical syndrome is a neurobiological disorder characterised by preoccupation with social concerns, delusions of superiority, and obsession with conformity. There is no known cure.' (Silberman, 2015; Location 6749.)

This tongue-in-cheek description of so-called 'normality' speaks to the constructions of health – and illness - that language and social mores create and influence.

The life experience of the participants frequently demanded that they consider their 'normal' through the eyes of their beholders, not through their own subjective constructs. Since participants tended to behave in ways that did not conform with societal assumptions about interpersonal safety or acceptable behaviour and boundaries, fear made others quick to try and corral, pathologize and contain according to their own subjective views.

Participants felt that the condition was far more complex than is widely assumed. Harry in particular felt that the mechanism of 'ADHD' operated on many levels affecting the way life was organised and when interacting with people. This felt to him like having 'blinkers of the mind'. In this study, 'ADHD' was reported by participants as an extremely complex and richly layered experience that placed intense demands on their biology, neurobiology, self-control

and sense of self, to say nothing of their existential need to make meaning.

Participants' awareness of the influence of both nurture and nature

All six of the individuals in this study had chequered histories of family dysfunction, non-supportive primary caregivers, attachment difficulties, depressed, alcoholic or absent parents either through abandonment or death, all of which contributed to additional impairments to their sense of self. Participants spoke of chaotic home environments, often with frequent moves, being sent off to boarding schools or abandoned in the home by sometimes dysfunctional caregivers who often themselves were suffering from mental health issues. All participants spoke of suffering on and off with depression, anxiety, low self-esteem, self-doubt and constant feelings of inadequacy. All participants had researched the condition very thoroughly and had been curious about the part that heredity played in their own condition, tentatively identifying which parent they were most likely to have inherited the condition from. Some research indicates that 34-40% of people diagnosed report a family history of 'ADHD' (Rowland et al., 2002).

Whether we account for 'ADHD' with reference to the influence of genetic heredity , or understand it through the perspective of the complexity of dysfunctioning neurological brain networks which produce the signs that are clustered together in a categorical description such as we find in the DSM-5 or ICD 10 and call 'ADHD', these medical model considerations 'raise no uncomfortable questions about how a society and culture might erode the health of its members, or about how the life in a family may have affected a person's physiology or emotional make-up.' (Maté, 2000).

It seemed very clear to participants, when looking back to their pasts, how their impaired behaviours and relationships could be accounted for through the perspective of 'ADHD'. They were also aware that contextual factors played at least an equal, if not a larger, part in their experience. Speaking directly to this, a recent editorial in JAMA Pediatrics (Nigg, 2018) focuses on the emergence of an epigenetic paradigm for understanding 'ADHD' and other

neurodevelopmental, mental and behavioural disorders, acknowledging the increasingly recognised role of the environment in 'ADHD' (2018). It is not the goal of this study to draw any aetiological conclusions, but supported by the voices of these participants, there is something intuitively compelling about the contribution of nurture when speaking about the relative impact and impairment degree of 'ADHD' in the life of an individual. At the very least dysfunctional nurture is likely to intensify symptomology and impairment, where a more benevolent developmental environment could offer better management of behaviours as well as actively encouraging self-worth and acceptance.

The impact of trauma, low self-esteem and self-doubt on self and other relationships

Participants had all struggled with relational trauma in their early development. Relational trauma is interpersonal, intended and prolonged trauma which can be more distressing that a singular traumatic event (Pearlman and Courtois, 2005). In the rupture of the selfobject tie between a caregiver and a child, the self state of the child may be dramatically altered. It is the narrative organisation through which experience is processed which impacts the individual (Mitchell, 2014). If we add to these effects the additional burden of misattuned neurological networking, trauma is likely to be even more profoundly impactful.

Dissociative emotional techniques are sometimes used to get away from the intensely overwhelming effects of traumatic over-stimulation. Disengaging from external stimuli in favour of attention to an internal world (Schore, 2002) is sometimes alleviating. Sarah talked about how retreating to her home, and in one case not being able to leave it for a couple of months after an occupational setback, was her way of managing the intensity of too much external stimuli. Huw's drinking was freely accepted by him as deeply rooted in his family culture, yet also something he used to dissociate from unbearable feelings. Heidi was clear that home was one of the only places where she felt safe and could be herself. Harry seemed at one remove from his affect and found relief in checking out of his environment through gaming. With participants there seemed to be a need both to disengage from both external and internal overstimulation. Emotional trauma was magnified by neurological assault.

All of the participants spoke about the physiological dysregulation that resulted from the effect of trying to sustain too much sensory overload coming from being, for example, in crowded spaces, or from the effort of trying to process the amount of interpersonal cues needing to be attended to in a group setting. This resulted in a physical and psychical exhaustion that is particular to 'ADHD' – a feeling of being absolutely rung out, accompanied by an intense and compulsive need to withdraw to a familiar or more stimulus-free environment. Heidi withdrew to her office or needed to take naps in the middle of the day to compensate. After a day at work, unmedicated and undiagnosed, Harry had had nothing left emotionally to give to his partner but retreated to sleep or video gaming. Huw retreated to his flat. Sarah escaped into daydreaming.

The inevitable tendency of 'ADHD' is to additionally compromise the power to organise and plan the execution of volitional acts, further shattering self-organisation. Participants were constantly beleaguered by this. Heidi had come to accept that if she had five household tasks to accomplish, her distractibility was such that she would start all the tasks one after the other, and with all of them on the go, work back and forth randomly and with no certainty of total completion until she either ran out of time orf got them all finished. The task-switching process kept her stimulated enough to have a hope of getting her housework done.

All the participants struggled with low self-esteem and self-doubt. Harry, Edward, Heidi and Huw in particular spoke about their unease in being unable to pick up, process and respond in a timely fashion to emotional and conversational cues. And both Edward and Huw felt that their capacity to know what they were feeling was quite severely compromised, not knowing whether to account for this by the traumatic emotional effects of 'ADHD' or their early relational deficits.

When you don't make sense to yourself

In the early development of the self, the primary elements thought to form an organised

sense of a core self include self-agency, self-coherence, self-affectivity and self-history (Stern, 1985). Included in the meaning of self-agency is having a sense of authorship of own's own actions, and this is compromised in the experience of the adult with 'ADHD'. Heidi tells us: 'What I achieved was chaos, disruption, distraction and madness. But that's not what I set out to achieve, my intention was totally the opposite…'. Harry felt that he was not in control of his own actions: 'If you can't rely on yourself to just do things when they need to be done, that's a problem.'

Being self-coherent means feeling like you are a non-fragmented, physical whole with boundaries and a locus of integrated action, both while behaving and when still (Stern, 1985). An absence of coherence can be experienced as feelings of depersonalisation – a symptom of anxiety which manifests as a sense of being disconnected or estranged from one's self. It was through the success of medication that some of the participants recognised the discrepancy between this apprehension of self and a compromised one: 'That was one of the weirdest things when I was first medicated. It was just I'm the person I want to be suddenly, you know?' (Harry). And Heidi on medication has an experience of getting back in touch with some more real self: 'I think hello, we're here. I'm active. I'm good now. I'm me again.'

When an individual does not have a sense that they are fully in control of their actions the result is their sense of agency in the world is diminished. Some core cognitive tasks that are proposed to be related to a functioning sense of self, and which are particularly pertinent in to the adult identifying with 'ADHD', are firstly that we be able to generate and intimately track motor commands in accordance with one's desires and beliefs about the world. Secondly, we assume that we are able to distinguish between environmental causes that we need to attend to and act on and those that are not relevant to current tasks, plans and preferences (Hohwy, 2007).

These cognitive tasks were compromised in participants. The effect was to lose track of how the world is and how it seems – of where the mind ends and the world begins - and of

the sense of themselves as reasonably cohesive persons able to discern and prioritise tasks and attend to salient features of the world (Hohwy, 2007). Joe's sense of himself was that he was 'battling to fit into life'. Harry and Edward could not make sense of why they could not seem to do things that others seemed to do with relative ease and even effortlessness. All the participants recognised that they had enormous difficulties translating organisational intention into either putting it down on paper coherently or mustering up enough motivation to get a task started, continued or completed.

All participants were both at once controlled and exasperated by the particular kind of boredom that attends 'ADHD' which is when the mind is being asked to attend to something that it is insufficiently stimulated by and which therefore does not stimulate enough executive circuitry to support and motivate task execution. It is like telling someone to run to somewhere when their feet are not allowed to touch the ground. This experience can be so painful at times it causes anxiety because it cannot be overcome by will power. It can be overridden only by a degree of focus that stress can engender, but if needing to be sustained over time can lead to levels of anxiety so intense they can result in panic attacks, pathological procrastination or burn out. It makes sense that there is a significant association of PTSD with 'ADHD' (Adler et al., 2004).

An aspect of self-concept all participants shared was self-doubt – an awareness that they could not rely on having any agency when it came to their behaviour – an inevitable consequence of the particular 'ADHD' experience of involuntary impulsiveness. This only added to participants' avoidance of situations or actions which might lead to another anticipated failure.

Participants' attachment experiences

Participants who took part in this study were recruited from grass-roots groups which focused on offering support to individuals who identified with 'ADHD'. The fact that all the individuals turned out to have chequered attachments histories seems to confirm the

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growing attachment literature that indicates a higher prevalence of 'ADHD' in individuals with insecure or disorganised attachment configurations.

It is posited that in secure attachment an attuned care giver's interactive regulatory response to an infant will alleviate distress and amplify positive emotions (Wallin, 2007). If a caregiver misattunes by being intrusive or dismissing, an infant will be unable to find emotional balance and will either feel overstimulated by the intrusion or abandoned to an unresolved emotional state which leads to dissociating from it to get away from the unbearable feelings. These dissociated feelings are what characterize insecure attachment experiences. If the dual process of rupture and repair remains within the emotional 'window of tolerance' Siegel talks about (1999), this affect synchrony is thought to modulate states of positive and negative arousal and are considered to be the 'building blocks of attachment and its associated emotions' (Schore, 2002).

All the participants' narratives displayed compromised early attachments, and their virtually constant state of hyperarousal resulted in an understandable over-sensitivity to sensory stimulation. Joe's difficulty with performing in group activities whether with peers or strangers gave him panic attacks. Huw recalled how he had had to steel himself to do his daily train commute without knowing why it affected him as stressfully as it did.

The varying individual experiences of 'ADHD'

The recounted experiences of the participants showed the heterogeneity of the condition across a variety of similar and dissimilar arenas. Heidi loved driving but was able to fully attend to road and speed signs only after taking medication for the first time; Sarah was unable to combine the foci of a coordinated mind and body in order to change gear and attend to the road at the same time and thus could not ever master the mechanics of driving a car. Harry could write analytic reports with ease, whereas Joe and Edward could not organise their thoughts well enough or motivate their physical selves to translate thoughts into words and put them down on paper, finding the task excruciatingly effortful.   Sarah

could successfully teach a classroom full of students but was stressed to the point of burnout having to sit at a desk that was in a public, noisy space. Huw could beat his peers hands down in getting to the core of a legal problem and providing a solution, but could not organise a cluttered office.

When we reflect on the qualities that characterise the 'ADHD' inner landscape it presents us with an argument against Cartesian dualism – the mind and body are clearly not independent from each other: 'The workings of the mind are determined in part by the substrate of a compromised brain or body' (Mollon, 2015). Something participants returned to repeatedly was their felt sense of the painful consequence of a brain network that is not functioning optimally which meant they could not count on themselves to follow through on what they wanted to, or on what was being asked of them by employer, partner or self. Failure is the verbal and non-verbal message they get back from their occupational and interpersonal worlds constantly. The fact that they cannot be predictable to themselves means that they must live in a constant state of uncertainty.

Reflections on other methods of doing this research

While the methodology of narrative inquiry has been chosen as suitable for allowing the voices of the participants in this study to be heard, it is not exclusive or the only fit for a study of adult 'ADHD'. It might be interesting to use grounded theory to see if any more generalised theory of ways of looking at the experience of individuals who are dealing with the specific neurobiological challenges of 'ADHD' could be established such as are found in the suggestions provoked by sensory integration theory (Ayres and Robbins, 2005). Conclusions could be made with the 'ADHD' population in mind. Thematic analysis could be helpful in teasing out the specific and repetitive symptomatic effects of 'ADHD' for individuals, or to clarify in a more detailed and targeted fashion the effects of impairments to the individual with 'ADHD'.

Online narratives were effectively used to analyse the narratives of adults who were

diagnosed with 'ADHD' in adulthood and meanings extracted from the narrators' accounts (Fleischmann and Miller, 2013) echoing the internalised negative views participants in this study also experienced and the increased coherence of their difficulties even a late diagnosis brought to their lives. These findings had been similarly outlined as noted in an earlier study (Young et al., 2008) about diagnosis in adulthood using Interpretative Phenomenological Analysis (IPA). Ghosh et al used a social constructivist approach using semi-structured interviews to extract themes around how 'ADHD' behaviour was perceived among parents of 'ADHD' children and adults with 'ADHD' in Western Australia (2016) finding that there was a real desire to 'fix' the symptoms, that diagnosis alleviated fault and identified the pressure to be 'normal' and to fit in with societal expectations. A 2012 study used Q-method (subjectivity assessed as a whole or a Gestalt) in discourse analysis to show that adults with 'ADHD' borrowed neurobiological, psychological, sociological and holistic arguments from public discourse to come up with a distinct set of discourses when structuring their descriptions of 'ADHD'. Neurobiology resonated with but did not dominate their thinking.

I found that the method of narrative inquiry allowed me to get up close and personal to the experience that was being told from participants' first-person points of view. This lent to the research relationship an interpersonal immediacy that I found informed, enhanced and instructed in ways similar to the therapeutic relationship.

Therapeutic guidelines for the treatment of adults with 'ADHD'

Introduction

Having focused in some detail on the narratives of adults who identify with 'ADHD', the aim in this section is to have this background and context serve as signposts for what might be helpful for practitioners who find themselves working with clients who present with the condition. Firstly, I establish the prevailing understandings and context in the treatment of the condition. Then I go on to discuss some of the considerations that are important in

working with clients with 'ADHD', beginning with client formulation and ending by taking us back to the views of the participants about what they felt would have helped them. Finally I have outlined these therapeutic guidelines in Table 2 (see p. 144).

Prevailing treatment wisdom

In this study, Joe, Harry and Heidi did find that medication helped their focus thereby causing a knock-on effect that increased their self-confidence. But medication did nothing for Edward and Huw, and Edward and Sarah had to stop taking medication because of side effects. In my own practice, and in anecdotal discussions with assessing GPs and psychologists, my experience is that while sometimes medication helps one or two aspects of the inattention and hyperactivity dimensions clients have struggled with, it is not designed to be nor is effective in reversing any impairments to self-esteem, self-understanding, self-acceptance, or an alleviator for the critical inner voice that is so often a relentless part of the internal 'ADHD' landscape.

NICE guidelines cite psychotherapy, usually in the form of CBT, as a second line option for the obvious reason that it is the behavioural aspects of the condition that are the main foci of such treatment. The implicit message is that these behaviours are troublesome in an interpersonal environment. The goal is to modify them by using strategies to train and better manage poor attention and memory, lack of organisation and/or haphazard timekeeping. There is a place for pragmatic treatment applications such as these (for a good example of this, see Jeavons et al., 2018) because 'ADHD' individuals experience themselves as problematic because of their differences on the behavioural spectrum. CBT is also the psychotherapy of choice to address the medical consequences to a self that is seen as intrapsychically, interpersonally and socially in deficit: anxiety and depression - that, in conjunction with anti-depressant and/or anti-anxiety medications. Coaching with behavioural modification in mind offer techniques targeting forgetfulness, procrastination, poor time-management, listening skills, and impulsiveness. This is a thriving industry in the US to treat 'ADHD' and grows larger in the UK each year particularly targeting children,

adolescents and students.

As a counselling psychotherapy clinician, I am more concerned with treatment needs which focus on the relational challenges to the adult with 'ADHD' which include both intrapsychic and intersubjective dimensions. This is informed by an understanding of what 'ADHD' symptomology does to the capacity of the individual to respond as well as how those responses may need to be reframed to facilitate self-healing. For adults with 'ADHD' who 'carry around with them for life experiences of unthinkable anxiety, and a deficit in the department of introjected reliability' (Winnicott, 1989a/1967) there is a need to work on the interpersonal schemata which have become lodged in the core of the person's self-concept and negatively influences their capacity to engage with self and other. And this may be separate from, but often one of the consequences of, their 'ADHD'.

When we encounter the adult who enters the therapy room seeking support for his or her 'ADHD', we are likely to be dealing with an individual who, while having likely been born with an inherited condition, has been dealing for a long time with the consequences of their neurodevelopmental network differences. More salient, perhaps, for the practitioner, is that we may be encountering an individual whose emotional infrastructure has been formed out of that particular 'ADHD' internal prism which has influenced and qualified their emotional development over the life span.

My intention here is to speak to the practitioner who wishes to work with adults who may or may not come with a formal diagnosis of 'ADHD' in hand. These clients may or may not wish to work specifically on behaviours arising from their experience of 'ADHD', but the guidelines which follow in this section of the dissertation are designed to offer some possible reflections that may be helpful for the practitioner to consider when working with such individuals.

In my experience, adult 'ADHD' clients who seek therapy tend to fall into one of two groups:

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1. Adults who have self-diagnosed themselves with 'ADHD' and are seeking therapeutic support.
2. Clients who have already been diagnosed, are either on medication or not, who seek therapy.

Clients in both groups may also want some help with strategies to better manage symptoms of their inattentiveness and focusing difficulties such as time management, procrastination or focus deficits.

There are also a smaller group of clients who may be seeking a formal assessment, diagnosis and treatment for what they have self-diagnosed as 'ADHD'. As only a psychiatrist is qualified to make a formal diagnosis, it may be helpful to have a list of local NHS clinics, psychiatrists who specialise in 'ADHD', or psychologists skilled in using quantitative and qualitative assessment tools, the conclusions of which are given to a psychiatrist to contribute to their final diagnosis and medication treatment. Formal assessment – not diagnosis – is recommended under the NICE guidelines to be done by competent clinical professionals which can include counselling psychologists, but this is not under consideration in this dissertation. My own feeling is that since there are a considerable number of co-occurring conditions that can accompany 'ADHD', and which can and do muddy the clinical waters, so to speak, assessment is best left to clinicians who have both the assessment tools and the clinical experience to reach a fully informed understanding of an adult who presents with 'ADHD' symptoms.

In some cases it may be a helpful tool for both therapist and client, with the client's permission, to administer a simple screening questionnaire, the ASRS v.1 (see Appendix 5) – which was developed by the World Health Organisation to provide a simple, effective indication of 'ADHD'. The client may then choose to pursue getting a formal assessment and diagnosis.

It is an established part of the extant literature on adults identifying with 'ADHD' that they

will often be suffering with additional conditions such as depression and anxiety. In fact, all the individuals in this study experienced depression and anxiety, some during the time of our association together, and all on frequent occasions in the past. There is a growing body of research currently being done focusing on 'ADHD' and other co-occurring conditions ranging from personality disorders to conditions on the spectrum, such as Asperger's and autism, as well as learning disabilities, such as dyslexia. It is however beyond the scope of this work to focus on these co-occurring conditions.

Considerations for formulation

In the room

The primary signs to be aware of in the initial presentation of the adult with 'ADHD' are associated with the restlessness, distractibility and impulsivity that usually characterise the experience of the individual. Clients may physically jiggle their legs, shift from topic to topic fairly rapidly in their speech and thought patterns, and in the countertransference, be experienced by the therapist as tightly wound, with possibly even a sense of barely repressed anxiety. They may speak of difficulty with sleep – either not being able to sleep all night through, or not being able to get to sleep because their brain refuses to turn off. They may apologise for themselves frequently.

Childhood

The narrative of childhood, in all the environments of home, school and socially, is likely to have been littered with negative feedback from teachers and caregivers. Clients may have been perceived as disruptive or inattentive. Teachers will often have seen the considerable capacity in individuals but be at a loss - an exasperation which sometimes turns into punitive or shaming communication - as to why the client is apparently choosing not to complete or turn in homework, finish projects or sit still in the classroom. Clients will often report assumptions of wilfulness ascribed to themselves as children. It may be supportive to help a

client tease out whether they have been aware, consciously or unconsciously, that they have knowledge of how to plan and execute, yet no matter how hard they try, have been unable to compel their own compliance and motivation to do so. Clients may be familiar with underlying feelings of dread and anxiety as well as poor self-esteem and self-doubt. Clients may manifest surface anger, which may be being used as a defence against anxiety and fear of failure.

Occupational history

If an adult with 'ADHD' has been fortunate, they will have found a niche in the workplace that feeds their need for constant stimulation to be motivated and offers enough structure to feel safe with the consequence of containing both impulsiveness and hyperactivity. But each individual finds these compatibilities in very different ways. Heidi, for example, gravitated towards working as an A&E nurse where she could be stimulated by life and death situations and the need to process a lot of information all at once which she was very good at in a crisis. Joe had become an entrepreneur, enjoying teaching cooking skills to children with disabilities, but found it impossible to manage the paperwork, fulfil the tasks of a public-facing marketing role or organise and then execute the details of a business plan. The role of the clinician in this regard will be to work with the client to differentiate between the skills and talents he or she has that can be utilised easily, those that might be improved upon, and those for which outside assistance may need to be sought. All the participants in the study felt enormous feelings of inadequacy at what they felt they ought to be able to achieve but could not make themselves do. Clinicians can help clients reduce anxiety and unrealistic expectations by supporting them to get to know their own 'ADHD' better and work with it rather than 'trying harder' which is usually the solution path adults with 'ADHD' have taken in the past.

Flexibility and containment around time management in the alliance

In general, there is no reason to assume that the therapeutic hour will be too difficult for

the adult with 'ADHD' to attend to or last through, nor is it inevitable that the client will always be late. However, both may occur. In the first case it may be important to distinguish between a client who is dealing with an issue that is provoking dissociative defences, and one who is being driven by a compromised executive function meaning the client can neither estimate time intervals effectively nor plan actions to fill them accordingly. The 'ADHD' client has little control over this deficit and has to learn how to either find a concrete strategy to manage this (setting a mobile phone alarm, for example) or 'trick' his brain into being reliable (this could mean arriving at a destination 30 minutes ahead of time to compensate for the anxiety of always being late).

In the second case, accepting a client's lateness with understanding is therapeutically advisable rather than assuming that one is working with a client's unconscious process which needs to be interpreted. Some clients may find it helpful if the therapist is willing to either send them a regular reminder ahead of the session or have the therapist work with the client to find a strategy that works for them. Reducing anxiety around time-keeping is a containing clinical intervention as it reinforces an acceptance of the client as they are.

Being heard and seen – therapeutic attachment

One of the common refrains in the narratives of the individuals in this study was the fact that, though each felt they did not know how to name their experience, what they were being told they were experiencing by clinicians did not quite add up to their own felt reality. Before they did their own research and came up with 'ADHD' as the closest explanation for what they were experiencing, they had been diagnosed with other conditions such as depression and personality 'disorder' (Joe), anxiety (Sarah), and grief (Harry). In the end, what was important for Joe was to have his story validated: 'I wanted to be bloody heard for once in my life.', '…. all this time I wanted someone to listen to me and they never did.' Intersubjective experience between therapist and client creates a space for new meaning, healing and growth as well as prepares the ground for a new understanding of self (Atwood and Stolorow, 2014).

As mentioned, 'feeling felt' is Seigel's term for the attunement of states between two people which forms the non-verbal basis of contingent collaborative communication (1999). It is an experience of vitality since feeling recognized by an other tells us that we have 'created meaning, had an impact, revealed an intention' (Benjamin, 1990). The clinician can facilitate the 'ADHD' client's exposure to a different attachment experience which can best be achieved with the 'ADHD' client through the use of empathy and introspection. Active listening can serve as essential scaffolding in structuring an empathic alliance with an 'ADHD' client. Done with sensitivity it results in the client feeling heard. As Benjamin points out so poignantly, the joy of this kind of intersubjective attunement for the client is to know that an other can share his or her feelings (1990), and in this sharing is a validation of themselves and their experience which bring coherence to a personal narrative that has often been experienced as fragmented and out of synch with external reality.

Differentiating between 'ADHD' and the self

Adults who have grown up believing that they are implicated and therefore to blame for the effects of their symptoms on the world around them have a deeply impaired sense of themselves. Their assaults on themselves as they try harder and harder to exert some control on their behaviour or predict the consequences of their actions often rises to the level of internal and relational trauma. In adults with 'ADHD', experiences in the present can often awaken feelings and emotional assumptions formed in a past that are actually not relevant to the current context. Adults with 'ADHD' are immeasurably helped, not only by being facilitated to see the association between feelings from the past with actions in the here and now, but also to establish a clear distinction between their intentional selves and their actual behaviours. These behaviours, it can be discovered, are in fact often driven involuntarily by the symptoms of the condition and represent a reaction to a stimulus without the benefit of an executive thought process that others by and large use to check and balance responses. It is very helpful to establish a clear distinction between who they are and the things they do.

Offering intersubjective attunement means that the 'ADHD' client can share his or her

feelings, and in this sharing and understanding of the effects of their 'ADHD' symptoms is a validation of self and experience which brings coherence to their personal narrative (Benjamin, 1990). The use of sustained empathic inquiry (Atwood and Stolorow, 2014) slows things down enough with 'ADHD' clients and they can find it a respectful and affirming process, creating a space to explore themselves reflectively. In this way they can become aware of how absent self-object responses, as well as neurological misattunements, have constricted and limited their experience of themselves in relationship with self and others.

Therapist and client as subjective and objective selves

'ADHD' clients often present with experiential deficits of themselves either as subject or object. In the first case they have difficulty identifying, let alone asserting, their own self-identity and reality. Their interpersonal boundaries are porous, and their locus of control resides in the other. In the second case, they have difficulty accepting the reality of others. They have a compromised capacity for empathy, impose their boundaries on others, and can often feel constantly victimized.

It is helpful to encourage the growth of an 'ADHD' client's awareness of their own subjectivity by the process of mirroring them back to themselves. As a mother, I found a figurative echo in my children's' implicit need for affirmative response and personal recognition when they shouted 'Look at me, Mama! Look at me!' when they swam alone for the first time or did a handstand without falling. 'ADHD' client boundaries are often both too tight and too loose, defensive responses reflecting their difficulties reading interpersonal cues. Allowing clients to express distress and anger or confusion without retaliation or abandonment can foster the development of internal resources to support themselves through future failures (Gilbert and Orlans, 2011). Validating their feelings by exploring them, as well as their underlying perceptions, restores a sense of personal reliability that is often the most evident aspect of what has become compromised for the 'ADHD' adult.

Treatment methods are relational acts (Newhill et al., 2003). Research consistently shows

that it is the therapy relationship which accounts for why clients improve at least as much as the particular treatment methods (Norcross and Wampold, 2011). When psychotherapy works, its benefits not only endure but can increase with time (Shedler, 2010). The engagement between therapist and 'ADHD' client promotes change in the expansion of affect tolerance and regulation of the right-lateralized 'emotional brain' and the human relatedness of the right-lateralized 'social brain' (Schore, 2002). This experience-dependent maturing of right brain circuits is thought to lead to the evolution of more complex psychic structures which enables the processing of more complex functions such as empathy, intersubjectivity, affect tolerance and stress regulation (Schore, 2002). The relational work done in this area may help to rework or bolster the effects on the sense of self of impaired neural networks. There is some evidence to support a view that when compensatory strategies are effective in the organisational, attentional, social, motoric and psychopharmalogical areas, they are perceived by 'ADHD' adults as personal skills or strengths, not deficits (Canela et al., 2017).

Focusing on self-regulation

We know that infants have no way of self-regulating the intensity of their emotions, the control process of which develops in the orbitofrontal system of the right brain hemisphere, with its cortical and subcortical connections (Schore, 2002). In addition, one of the primary roles of the dopaminergic and oxytocynergic endocrine systems appears to be to modulate stress responses so as to facilitate optimal social bonding and attachment (Strathearn, 2018). Interactions between mother and infant are imprinted into pre-verbal memory as internal working models (Bowlby, 1969) which become their characteristic ways of regulating stress, fear and proximity seeking (Strathearn, 2018).

'ADHD' clients live in an internal world that is tuned to hypervigilance due to the hyperactivity of the brain and the cascading thoughts that result, as well as a history often marked by frequent failures of self-efficacy. Helping the 'ADHD' client to recognise this for what it is and to identify these response patterns enables the therapist to make sense, in

collaboration with the client, of where these internal structures may not, or may no longer be, serving them in achieving emotional homoeostasis which is their inner felt experience striving to match their perceptions of self in the world.

Avoiding overwhelm – breaking things down

Something which goes hand in hand with self-regulation in the 'ADHD' client is developing an understanding of ways to avoid becoming emotionally overwhelmed. This often results when a client is not able to prioritise tasks or decisions or sort through the overload of external or internal stimuli which become impossible to cognitively and emotionally process. It helps to talk to the 'ADHD' client about ways to create internal boundaries for themselves that allow them to feel safe emotionally and in control of themselves. One of the best ways to do this is by breaking things down into small steps. One client I had was frustrated by his inability to get to the gym. He loved being there, he was committed to his intended fitness regime before a planned surfing holiday but was absolutely frustrated that he could not motivate himself to go the gym. We worked on him simply walking in through the door of the gym which was half way between his home and his work. That proved to be a small enough step to achieve and allowed him to follow through on his intention.

Harry found it helpful to Google videos so he could to inform himself about others' experiences of 'ADHD', as well as see in writing the list of possible signs that someone might have with the condition: "…what helped me come terms with the fact that I had 'ADHD' was just having a very clear step by step understanding…. like a very clear list of all the things it affects.'

Breaking things down into manageable chunks reduces stress, facilitates motivation and helps the 'ADHD' client use their often-considerable skills and talents in their own service.

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Make the invisible visible

Adults with 'ADHD' may have spent a long time not understanding themselves and not being understood. Having 'ADHD' does not 'look like' anything is medically wrong with the person, and the dilemma is that either the person must make huge efforts to try to hide and disavow the internal and interpersonal consequences and be blamed for behaviours that impact others negatively, or declare it and have to deal with public value judgements which often stigmatise and risk the person having to live with a socially devalued self-identity. Huw felt keenly the devastation of his life and his advice to others was:

> 'I would say take it very seriously and get as much support as you can. Don't.... just think it'll go away, because it won't, it's a very serious thing that could be life threatening almost, if you don't take it seriously.... I've been in suicidal despair a lot of times, and a lot of it is the result of things that have happened or not happened because of my 'ADHD'. So be nice and kind to yourself.'

It is useful therefore to be factual and matter-of-fact about 'ADHD'. Taking the stance that you are working with a condition that can be managed so that the person is in charge of it, rather than being on the other end of something out of their control, is relieving for the 'ADHD' client. It reduces it from monster status to unruly puppy dimensions.

Exploring in detail the particular characteristics of the client's manifestation of 'ADHD' symptomology, as well as the damage to self, allows you both to come up with strategies to manage it. For one client it will be how to perhaps identify an internal script: 'I am afraid to try because I will only fail again' and coming up with different ways of approaching the dreaded task or meeting. For another client it may be identifying what they need in terms of a suitable work environment to be able to produce effectively. For another, like Sarah, it may be working with her to give herself permission to paint on a regular basis because it soothes her and brings much needed internal relief from her overactive brain as well as support her in teaching her family that she cannot be the family member who organises overflowing

cupboards.

It is important to pay attention to the client's anxiety. By noticing it, talking about it, and acknowledging it, not as pathology but as an informative part of themselves, it becomes not something to be expelled, but to be welcomed as a message from themselves. Practicing how to stop and respond to anxiety's challenge becomes a helpful tool for the client, creating as it does a reliable self-soothing dialogue process with themselves.

Putting words around 'ADHD' experience

While it may sound self-evident, giving individuals with 'ADHD' a vocabulary for what they are experiencing can be enormously boundary making for them. Enabling them to consider their impulsiveness as the function of a brain which does not have an internal mechanism for putting temporal distance between stimulus and response gives the client a way to differentiate between themselves and their behaviours and to create the possibility of imagining ways to create that 'pause' space. Explaining to a client that their lack of personal motivation is because there is a part of their brain which needs more stimulation than normal to 'wake up' and act on their intention helps to validate their intention, even if they are unable yet to move from thought to task. To describe their anxiety as something driven by a racing brain that has an electric, cattle-prod quality which is quite different from worry, which can move to anxiety and then sometimes to panic, is specific and relieving because that specificity is at one remove from themselves.

Using imagery and metaphor therapeutically has been shown to be useful at a general strategic level using a single metaphor throughout treatment and attuned to the language and meaning of each individual client (Witztum et al., 1988). In Heidi's case, for example, using images and metaphors and imagery from the world of hospital and nursing care as well as the realm of medical management provided an attuning language that formed a bridge for me as therapist to see and hear her world and use it as a therapeutic metaphor for her own experience of herself.

At other times language and metaphor can be used to address specific aspects or issues within treatment, and this may sometimes be explored with the client on a trial and error basis. Exploring the possible comparisons between Harry's video game playing and his appreciation for the worlds of a favourite fantasy author did not yield insights directly but did set him off on a productive reflection around how his interests in both worlds said something about differences in himself as a result of 'ADHD' that he was intrigued to identify. One of the greatest values of using metaphor is that it can deactivate defences without heightening anxiety because the client can defocus on a perhaps trauma-laden issue and reframe it from the interchange in the metaphoric field (Witztum et al., 1988).

Interspersing practical strategies

If we separate for a moment the consequences to the damaged self in an 'ADHD' presentation which include low self-esteem, low self-confidence and impaired interpersonal relations, there is usually also a need to be familiar with and suggest strategies for management of time, memory, procrastination, listening skills, and other practical life skills. These kinds of coaching strategies are beyond the focus of this dissertation but some resources for these are listed in Appendix 7.

What participants said would help them

One of the final interview questions participants were asked was what they thought would have helped them. All the participants were clear that being diagnosed earlier and having had access to more and earlier education about 'ADHD' would have been desirable. Having explanations for their behaviours would also have helped. The fact that not enough clinicians knew what 'ADHD' is or could recognise the symptom constellation was felt to have caused participants wasted years on a wild goose health chase trying to account for their internal experience. Not only that, but many health care professionals were perceived to be unsympathetic. Each participant yearned to varying degrees that someone had known more about 'ADHD' when they were children to help them interpret their behaviours and guide

them to better ways of understanding themselves and managing the condition.

Though it was not specifically addressed, participants' experience of counselling came up. Joe's one experience of therapy was with someone whom he felt conflated the impact of his childhood sexual abuse with the effects of 'ADHD' thereby causing him unintentionally to subsequently experience more shame and confusion. Joe also expressed the opinion that it was important for a therapist to engage with an 'ADHD' client, not just offer silent listening. Edward had had some CBT counselling for his depression but did not find it that effective and had been frustrated that no one was concerned or knowledgeable about the contributions 'ADHD' may have made. Heidi was only interested in counselling if it could alleviate the hyperactivity or focus issues of the condition but, having developed into a radically defended self because of her early developmental trauma and scepticism of the health system, did not feel she needed it, preferring to manage by herself. She did think counselling professionals should understand the struggle behind the façade of the 'ADHD' individual, how chaotic the 'ADHD' brain is and how hard it is to concentrate.

Huw had had quite an extended series of counselling sessions using a variety of different modalities: CBT, schema therapy and compassion-focused therapy through the NHS's Improving Access to Psychological Therapies programme. Therapy had given him coping skills and helped him accept himself and brought enough self-understanding that he was willing to declare his 'ADHD' as a disability and get support from the state without feeling too much like a 'scrounger'. More importantly the intimacy of the therapeutic alliance offered him a relational experience that was rare for him and therefore highly valuable: 'I've got this kind of idea that this psychologist is like my mummy! She's so kind, she has been so kind to me. And now…. it's going to end…it's quite depressing to find that out.'

Joe wanted help to like himself better, and Harry wanted help to break bad behavioural habits such as eating lunch at his desk instead of connecting with others and engaging relationally. He also wanted relational skill building: following up, keeping in touch, not losing his train of thought in mid-conversation. Edward wanted to learn how to prioritise

better and Heidi to improve her management of others' expectations.

In looking back on their stories all the participants imagined that knowing about their 'ADHD' would have meant that they would have been simultaneously relieved of the awful responsibility they bore for being 'bad', 'naughty', 'misbehaving' and, most of all, for not achieving their potential. Some resilient part of them knew that they were capable of more, intellectually or physically. As powerless children they needed to be able to rely on authoritative and knowledgeable adults to make sense of their personal narratives to validate them, and no one did. This is a very Kohutian aspiration. There is a place for the therapist to become the kind of mirroring self-object and idealised parent imago Kohut talks about which allows for the damaged 'ADHD' self 'to begin to re-establish a state of cohesion, vigour and inner harmony' (Kohut and Wolf, 1978: p. 413).

Participants generally wanted and needed self-understanding around their strengths and weaknesses because of 'ADHD'. Harry wanted to find the things that 'fit people like me' and while Edward had found that being diagnosed helped make sense of his life, Huw hoped that increased self-understanding might lead to increased self-confidence. This desire to understand strengths and weaknesses included adapting work environments to match up so that good occupational outcomes might be achieved. In some cases this meant managing the declaration of their 'ADHD' as a disability.

Joe felt that being able to discern what was best for him would have been helpful and Harry wanted help to ascertain if his own vision of himself matched what he felt might be his actual self, which I understood to mean an exploration and bolstering of his subjective and objective selves. All the participants wanted to build self-confidence with Edward seeing this as a matter of not taking on too many challenges at once and Heidi feeling this was about managing her expectations of what she could achieve in a day. Huw still struggled with the internal message that he was not working hard enough and needed to try harder.

Joe was clear that having safe emotional environments in which there was acceptance

without judgement was important and Harry and Heidi had benefitted from being able to get work support. Talking to other 'ADHD' groups was useful for Edward to acquire knowledge of 'ADHD' and to hear similar experiences from others; attending other support groups had helped Huw to accept his 'disability'. Participants felt that having the right people supporting you was even more important, sometimes just to listen and accept, but often to follow up or push you to do something. Eliciting the skills of others to compensate for what you cannot do or procrastinate over was also seen as helpful. Having external structure was felt to be critical for almost all the participants and finding ways to break tasks down into smaller steps enabled completion and a sense of achievement.

Table 2 – Therapeutic Guidelines

Formulation	*Note the somatic markers of 'ADHD', also academic, occupational and relational evidence of failure despite capacity and/or intention.*
Time management	*Allow for a compromised relationship with time. Offer to send reminders for sessions but respect the client's desire to manage this in their own way.*
'Feeling felt'	*Recognise and validate the ADHD client's internal and external reality through active listening*
Differentiate between the self and the 'ADHD'	*Work with the client to identify the difference between who they are and their behaviours*
Subjective and objective selves	*Work to establish better internal boundaries for the subjective self while reducing the impact of an objective self that has been informed by a critical outside world*
Being heard and seen	*Use of empathy and introspection to support and reframe a client's perceptions of self and others*
Self-regulation	*Draw attention to the physiological and unconscious processes of anxiety*
Avoiding overwhelm	*Working with the client to identify and attend to their somatic markers to access and apply stress reducing steps*
Making the invisible visible	*Identify the client's particular manifestations of 'ADHD' – and work with them to identify strengths and weaknesses*
Clinical use of language	*Metaphors and imagery can be used to deactivate client defences and reframe what have formerly been perceived as deficits*
Behaviour modification	*Be knowledgeable and prepared to use coaching strategies occasionally to help a client manage their 'ADHD' behaviours*

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Reflections

Caveats and limitations of this study

Clearly this study was never intended to generalise any of its findings to the global population of adults with 'ADHD'. But just as each new therapeutic experience with another 'ADHD' client adds something unique and effective to the work with the next client, this study embodies something of the same intent.

Each of the six participants had a unique story yet came from a context that was not inclusive and diversified. The individuals who spoke in this narrative inquiry were from a part of the U.K that is quite affluent by comparison to other geographic regions in the nation. The U.K. itself is developed, wealthy, Western and defined by a very specific set of cultural, political, historical, educational and social contexts. Thus the narratives unconsciously reflected the values, biases and assumptions that are present in these contexts. All of the participants were white and English-speaking. None of them was black or from an ethnic minority. I, too, bring my age, upbringing, nationality, gender, education, history, beliefs and training to the research mix.

These stories do not reflect another vulnerable 'ADHD' population – offenders – for whom 'ADHD' is often salient and implicated in their crimes. When comprehensive clinical assessments were conducted in U.K. prison settings, 30% of adults, 10% of females, and a disturbingly high 45% of youth offenders were found to be experiencing symptoms of 'ADHD' (Young and Thome, 2011). The stories of this offender group will perhaps reflect their accidents of birth, context and the unlucky consequences of their impulsivity, but also bear telling.

The original intent of this research was to explore the experience of adults who had been diagnosed with 'ADHD' in their childhood. That turned out not to be the personal story of any of the individuals who responded to my initial search for participants. At first, this

appeared as something of a dilemma. I considered rejecting these proffers of participation in favour of seeking out participants who more specifically fit the intended criteria.

My starting point had been heavily influenced by my son's, and my own, experience of his 'ADHD'. But the 'big picture' purpose was to give a voice to adults with 'ADHD' and, after reflecting, I concluded that here were adults identifying with 'ADHD' who were clearly wanting their voices to be heard. Not only did using the experience of these participants not violate the core purpose of the inquiry as I had conceived it, it actually validated it.

What difference would it have made to this study if I had been able to stick to the original plan? Not much, if I use my son as a contrasting example of someone who had received the diagnosis of 'ADHD' in childhood. He still has had to cope with a largely sceptical professional and occupational world, where pockets of awareness and knowledge of the condition show up, but not in enough depth to really offer meaningful support or accommodation for his particular set of needs. Medication has not really worked for him, and the distractions and responsibilities of a young family make it difficult for him to carve out much self-care time. He is lucky to have a considerable well of emotional intelligence to guide him, and a great sense of determination, but depression, anxiety and low self-esteem have nipped at his heels, despite the love and support of friends and family. Of course his case is not the only one exemplifying this group, but it is perhaps anecdotally and individually illustrative.

This study did not look at adults who identify with 'ADHD' who were diagnosed as children, nor did it focus on gender, cultural or age differences, all of which are proving fruitful areas for current study.

Final thoughts

I knew when I first submitted my research proposal that I wanted, and felt I would need, to have a fair degree of clinical experience working with adults who identified with 'ADHD' if

I was to do the topic justice. Just because I had the personal experience with my son and my observations of our experience of 'ADHD', I did not feel this was enough to give voice to what it is like to be someone dealing with the internal and external consequences of having the condition. In my private practice, I have specialised in supporting adults with 'ADHD'. Of all the clients I have now seen over the years, none of them has really felt completely understood by clinical professionals when it comes to their 'ADHD' experience, so it has been gratifying to use this forum to begin to rectify this omission.

When I began this process, I was somewhat intimidated by the weight of the medical model view of the condition. 'ADHD' is seen as a medical diagnosis. That world, focused as it is almost exclusively on symptom alleviation and behaviour change, did not seem to account for the impairment of self to self, and self to others, that adults with 'ADHD' often contend with. Being an integrative psychotherapist, attending to this relational view feels as if it is one of the most critical aspects of the work with an individual with 'ADHD', and needs to be included in any treatment plan if the wellness of the whole person is being considered. The work with the participants in this study, and my client work, has only solidified my belief in this regard.

In my original proposal presentation, one of my peers asked me if I thought that 'ADHD' might be the result of poor or ignorant parenting – essentially a nurture rather than a nature argument. I was not convinced that was the case, but remember feeling unsure, probably fuelled in part by the small, perhaps inevitable, twinges of guilt that my own son's 'ADHD' might have been caused by a lack in my own parenting. In doing this research, I have come to be less concerned about the aetiology of the condition and have become convinced that in 'ADHD' there is a definite neurological/biological presence at work in the individual. And there is much to learn from a closer examination of the links between early neurological and emotional development and the many conditions which fall under the rubric of 'mental illness'. In other words the epigenetic works hand in hand with the biological. Where I have ended up as a clinician with regard to adult clients with 'ADHD' is to be even more firmly

committed to the alleviation of suffering, the holding of hope and the affirmation of the self, all firmly underpinned by the meaning-making that comes from healthy doses of informed psychoeducation on the condition.

References

Adler, J. M. & McAdams, D. P. 2007. Time, culture, and stories of the self. *Psychological Inquiry,* 18**,** 97-99.

Adler, L., Kessler, R. C. & Spencer, T. 2003. Adult ADHD self-report scale-v1. 1 (ASRS-v1. 1) symptom checklist. *New York, NY: World Health Organization*.

Adler, L., Kunz, M., Chua, H., Rotrosen, J. & Resnick, S. 2004. Attention-deficit/hyperactivity disorder in adult patients with posttraumatic stress disorder (PTSD): is ADHD a vulnerability factor? *Journal of Attention Disorders,* 8**,** 11-16.

Adler, L., Spencer, T., Stein, M. A. & Newcorn, J. H. 2008. Best practices in adult ADHD: epidemiology, impairments and differential diagnosis. *CNS Spectr,* 13**,** 4.

Alexander, L. & Farrelly, N. 2017. Attending to adult ADHD: a review of the neurobiology behind adult ADHD. *Irish Journal of Psychological Medicine***,** 1-8.

Alvarado, C. 2015. I'm not all that: a look at the imposter phenomenon in intimate relationships.

Anttila, V., Bulik-Sullivan, B., Finucane, H. K., Walters, R. K., Bras, J., Duncan, L., Escott-Price, V., Falcone, G. J., Gormley, P., Malik, R., Patsopoulos, N. A., Ripke, S., Wei, Z., Yu, D., Lee, P. H., Turley, P., Grenier-Boley, B., Chouraki, V., Kamatani, Y., Berr, C., Letenneur, L., Hannequin, D., Amouyel, P., Boland, A., Deleuze, J.-F., Duron, E., Vardarajan, B. N., Reitz, C., Goate, A. M., Huentelman, M. J., Kamboh, M. I., Larson, E. B., Rogaeva, E., St George-Hyslop, P., Hakonarson, H., Kukull, W. A., Farrer, L. A., Barnes, L. L., Beach, T. G., Demirci, F. Y., Head, E., Hulette, C. M., Jicha, G. A., Kauwe, J. S. K., Kaye, J. A., Leverenz, J. B., Levey, A. I., Lieberman, A. P., Pankratz, V. S., Poon, W. W., Quinn, J. F., Saykin, A. J., Schneider, L. S., Smith, A. G., Sonnen, J. A., Stern, R. A., Van Deerlin, V. M., Van Eldik, L. J., Harold, D., Russo, G., Rubinsztein, D. C., Bayer, A., Tsolaki, M., Proitsi, P., Fox, N. C., Hampel, H., Owen, M. J., Mead, S., Passmore, P., Morgan, K., Nöthen, M. M., Schott, J. M., Rossor, M., Lupton, M. K., Hoffmann, P., Kornhuber, J., Lawlor, B., McQuillin, A., Al-Chalabi, A., Bis, J. C., Ruiz, A., Boada, M., Seshadri, S., Beiser, A., Rice, K., van der Lee, S. J., De Jager, P. L., Geschwind, D. H., Riemenschneider, M., Riedel-Heller, S., Rotter, J. I., Ransmayr, G., Hyman, B. T., Cruchaga, C., Alegret, M., Winsvold, B., Palta, P., Farh, K.-H., Cuenca-Leon, E., Furlotte, N., et al. 2018. Analysis of shared heritability in common disorders of the brain. *Science,* 360.

APA 2013. *Diagnostic and statistical manual of mental disorders (DSM-5®),* (American Psychiatric Association), American Psychiatric Pub.

Asherson, P. 2005. Clinical assessment and treatment of attention deficit hyperactivity disorder in adults. *Expert Review of Neurotherapeutics,* 5**,** 525-539.

Asherson, P., Adamou, M., Bolea, B., Muller, U., Morua, S. D., Pitts, M., Thome, J. & Young, S. 2010. Is ADHD a valid diagnosis in adults? Yes. *BMJ,* 340.

Atwood, G. & Stolorow, R. 1984. Structures of Subjectivity: Explorations. *Psychoanalytic Phenomenology*.

Atwood, G. E. B., Bernard & Stolorow, R. D. 2014. *Psychoanalytic treatment: An intersubjective approach*, Routledge.

Ayres, A. J. & Robbins, J. 2005. *Sensory integration and the child: Understanding hidden*

sensory challenges, Western Psychological Services.

Bandura, A. 1977. Self-efficacy: toward a unifying theory of behavioral change. *Psychological review,* 84**,** 191.

Baughman, F. A. The totality of the ADD/ADHD fraud. National Institutes of Health Consensus Conference on ADHD, 1998.

Benjamin, J. 1990. An outline of intersubjectivity: The development of recognition. *Psychoanalytic Psychology,* 7**,** 33.

Benjamin, J. 2014. Beyond Doer and Done to: An Intersubjective View of Thirdness 1. *Relational Psychoanalysis, Volume 4.* Routledge.

Bhaskar, R. 2010. *Reclaiming reality: A critical introduction to contemporary philosophy*, Routledge.

Biederman, J., Faraone, S. V., Mick, E. & Spencer, T. 1995. High risk for attention deficit hyperactivity disorder among children of parents with childhood onset of the disorder: a pilot study. *The American journal of psychiatry,* 152**,** 431.

Bowlby, J. 1969. *Attachment and Loss Vol 1 (1969),* New York, Basic Books.

BPS. 2011. *Attention Deficit Hyperactivity Disorder (ADHD): Review proposal consultation. (BPS response to the National Institute for Health and Clinical Excellence).* [Online]. Available: https://www1.bps.org.uk/sites/default/files/ADHD%20%28NICE%20-%20review%29%20-%20BPS%20response.pdf [Accessed June 13 2018].

BPS. 2014. *BPS Code of Human Research Ethics* [Online]. Available: https://www.bps.org.uk/news-and-policy/bps-code-human-research-ethics-2nd-edition-2014 [Accessed 26 April 2019].

Bramham, J., Young, S., Bickerdike, A., Spain, D., McCartan, D. & Xenitidis, K. 2009. Evaluation of group cognitive behavioral therapy for adults with ADHD. *Journal of Attention Disorders,* 12**,** 434-441.

Brod, M., Pohlman, B., Lasser, R. & Hodgkins, P. 2012. Comparison of the burden of illness for adults with ADHD across seven countries: a qualitative study. *Health Qual Life Out,* 10.

Bröer, C. & Heerings, M. 2013. Neurobiology in public and private discourse: the case of adults with ADHD. *Sociology of Health & Illness,* 35**,** 49-65.

Bromberg, P. M. 2011. *The shadow of the tsunami: And the growth of the relational mind*, Routledge.

Browne, A. & Finkelhor, D. 1986. Impact of child sexual abuse: A review of the research. *Psychological bulletin,* 99**,** 66.

Bruner, J. S. 1986. *Actual Minds, Possible Worlds*, Harvard University Press.

Bury, D. & Strauss, S. M. 2006. The scientist-practitioner in a counselling psychology setting. *The modern scientist-practitioner: A guide to practice in psychology*, 112-126.

Canela, C., Buadze, A., Dube, A., Eich, D. & Liebrenz, M. 2017. Skills and compensation strategies in adult ADHD–A qualitative study. *PloS one,* 12**,** e0184964.

Carley, K. 1993. Coding choices for textual analysis: A comparison of content analysis and map analysis. *Sociological methodology*, 75-126.

Carlson, E. A., Yates, T. M. & Sroufe, L. A. 2009. Development of dissociation and

development of the self. *Dissociation and the dissociative disorders. New York: Routledge.*

CDC. *Attention-Deficit/Hyperactive Disorder* [Online]. USA: Centers for Disease Control and Prevention. Available: https://www.cdc.gov/ncbddd/ADHD/data.html [Accessed April 20 2017].

Chase, S. E. 2005. *Narrative Inquiry: Multiple Lenses, Approaches, Voices,* Thousand Oaks, CA, Sage Publications.

Chase, S. E. 2007. Multiple lenses, approaches, voices. *Collecting and interpreting qualitative materials,* 57**,** 651-679.

Chiron, C., Jambaque, I., Nabbout, R., Lounes, R., Syrota, A. & Dulac, O. 1997. The right brain hemisphere is dominant in human infants. *Brain: a journal of neurology,* 120**,** 1057-1065.

Clandinin, D. J. 2013. Engaging In Narrative Inquiry. *Developing qualitative inquiry,* 9.

Clandinin, D. J. & Connelly, F. M. 2000. Narrative inquiry: Experience and story in qualitative research.

Comments, B. S. 2008. *Stakeholder Comments* [Online]. British Psychological Society for NICE Guidelines on ADHD. Available: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKEwi0m6ypw8vbAhXLLcAKHW5vC3kQFggsMAA&url=https%3A%2F%2Fwww1.bps.org.uk%2Fsites%2Fdefault%2Ffiles%2FADHD%2520%2528NICE%2529%2520-%2520BPS%2520response.pdf&usg=AOvVaw0WKFRqBtBAFIyhBCThU2CN [Accessed June 11 2018].

Connelly, F. M. & Clandinin, D. J. 1990. Stories of experience and narrative inquiry. *Educational researcher,* 19**,** 2-14.

Conners, C., Erhardt, D. & Sparrow, E. 1999. Conners' Adult ADHD Rating Scales: Technical Manual. 1999. *New York: Multi Health System.*

Crittenden, P. M. & Kulbotton, G. 2007. Familial contributions to ADHD: An attachment perspective. *Tidsskrift for Norsk Psykologorening,* 10**,** 1220-1229.

Dallos, R. & Vetere, A. 2005. *Researching psychotherapy and counselling*, McGraw-Hill Education (UK).

Dell, P. F. & O'Neil, J. A. 2010. *Dissociation and the dissociative disorders: DSM-V and beyond*, Routledge.

Devinsky, O. 2000. Right cerebral hemisphere dominance for a sense of corporeal and emotional self. *Epilepsy & Behavior,* 1**,** 60-73.

Epstein, J. N. & Loren, R. E. 2013. Changes in the definition of ADHD in DSM-5: subtle but important. *Neuropsychiatry,* 3**,** 455.

Erdman, P. 1998. Conceptualizing ADHD as a contextual response to parental attachment. *American Journal of Family Therapy,* 26**,** 177-185.

Etherington, K. 2000. *Narrative approaches to working with adult male survivors of child sexual abuse: The clients', the counsellor's and the researcher's story*, Jessica Kingsley London.

Feldman, M. S., Sköldberg, K., Brown, R. N. & Horner, D. 2004. Making sense of stories: A rhetorical approach to narrative analysis. *Journal of Public Administration Research*

and Theory, 14**,** 147-170.

Fihrer, I., McMahon, C. A. & Taylor, A. J. 2009. The impact of postnatal and concurrent maternal depression on child behaviour during the early school years. *Journal of Affective Disorders,* 119**,** 116-123.

Finlay, L. 2002. "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative health research,* 12**,** 531-545.

Fitzgerald, M. H. & Paterson, K. A. 1995. The hidden disability dilemma for the preservation of self. *Journal of Occupational Science,* 2**,** 13-21.

Fleischmann, A. & Miller, E. C. 2013. Online narratives by adults with ADHD who were diagnosed in adulthood. *Learning Disability Quarterly,* 36**,** 47-60.

Frankl, V. E. 1985. *Man's search for meaning*, Simon and Schuster.

Garland, C. 1998. Thinking about trauma. *Understanding trauma: A psychoanalytical approach***,** 9-31.

Gerber, P. J. 2001. Employment of adults with learning disabilities and ADHD: Reasons for success and implications for resilience. *The ADHD Report,* 9**,** 1-5.

Gergen, K. J. 2001. Psychological science in a postmodern context. *American psychologist,* 56**,** 803.

Ghosh, M., Fisher, C., Preen, D. B. & Holman, C. D. A. J. 2016. "It has to be fixed": a qualitative inquiry into perceived ADHD behaviour among affected individuals and parents in Western Australia. *BMC Health Services Research,* 16**,** 141.

Gilbert, M. & Orlans, V. 2011. *Integrative therapy: 100 key points and techniques*, Routledge.

Gilmore, K. 2000. A psychoanalytic perspective on attention-deficit/hyperactivity disorder. *Journal of the American Psychoanalytic Association,* 48**,** 1259-1293.

Greenhalgh, T. & Hurwitz, B. 1999. Why study narrative? *BMJ: British Medical Journal,* 318**,** 48.

Halasz, G. & Vance, A. L. 2002. Attention deficit hyperactivity disorder in children: moving forward with divergent perspectives. *Medical Journal of Australia,* 177**,** 554-557.

Hansson Halleröd, S. L., Anckarsäter, H., Råstam, M. & Hansson Scherman, M. 2015. Experienced consequences of being diagnosed with ADHD as an adult – a qualitative study. *BMC Psychiatry,* 15**,** 31.

Hartl, T. L., Duffany, S. R., Allen, G. J., Steketee, G. & Frost, R. O. 2005. Relationships among compulsive hoarding, trauma, and attention-deficit/hyperactivity disorder. *Behaviour Research and Therapy,* 43**,** 269-276.

Hawksley, R. 2017. Rory Bremner: 'Being officially diagnosed with ADHD in my fifties has been overwhelming' *The Telegraph*, 21 April 2017.

Herman, J. 1992. *Trauma and recovery: the aftermath of violence-from domestic abuse to political terror*, Basic Books.

Hill, J. C. & Schoener, E. P. 1996. Age-dependent decline of attention deficit hyperactivity disorder. *The American Journal of Psychiatry,* 153**,** 1143.

Hinshaw, S. P., Owens, E. B., Wells, K. C., Kraemer, H. C., Abikoff, H. B., Arnold, L. E., Conners, C. K., Elliott, G., Greenhill, L. L. & Hechtman, L. 2000. Family processes and treatment outcome in the MTA: Negative/ineffective parenting practices in relation to multimodal treatment. *Journal of Abnormal Child Psychology,* 28**,** 555-568.

Hohwy, J. 2007. The sense of self in the phenomenology of agency and perception. *Psyche,*

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13, 1-20.

Hoshmand, L. T. 2005. Narratology, cultural psychology, and counseling research. *Journal of Counseling Psychology,* 52, 178.

Jeavons, A., Bastable, S., Bishop, T. & French, B. 2018. *The Adult ADHD Treatment Handbook*, Routledge.

Johnson, S. M. 1994. *Character styles*, WW Norton & Co.

Kessler, R. F., J., Graaf, R., Alonso, J., Angermeyer, M. & Demyttenaere, K. 2007. Cross-national prevalence and correlates of adult attention-deficit hyperactivity disorder. *Brit J Psychiat,* 190.

Knouse, L. E., Cooper-Vince, C., Sprich, S. & Safren, S. A. 2008. Recent developments in the psychosocial treatment of adult ADHD. *Expert review of neurotherapeutics,* 8, 1537-1548.

Kohut, H. 1984. *How does analysis cure?*, Univ. Chicago Press.

Kohut, H. & Wolf, E. 1978. The Disorders of the Self and their Treatment: An Outline. *International Journal of Psycho-Analysis,* 59, 413-425.

Kooij, S. J., Bejerot, S., Blackwell, A., Caci, H., Casas-Brugué, M., Carpentier, P. J., Edvinsson, D., Fayyad, J., Foeken, K. & Fitzgerald, M. 2010. European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. *BMC psychiatry,* 10, 67.

Lebowitz, M. S. 2016. Stigmatization of ADHD. *Journal of Attention Disorders,* 20, 199-205.

Leech, N. L. & Onwuegbuzie, A. J. 2008. Qualitative data analysis: A compendium of techniques and a framework for selection for school psychology research and beyond. *School Psychology Quarterly,* 23, 587-604.

Lensing, M. B., Zeiner, P., Sandvik, L. & Opjordsmoen, S. 2015. Quality of life in adults aged 50+ with ADHD. *Journal of attention disorders,* 19, 405-413.

Letourneau, N. L., Tramonte, L. & Willms, J. D. 2013. Maternal depression, family functioning and children's longitudinal development. *Journal of Pediatric Nursing,* 28, 223-234.

Lieblich, A. & Josselson, R. 1997. *The narrative study of lives*, Sage.

Lincoln, Y. S. & Guba, E. G. 1985. *Naturalistic inquiry*, Sage.

Littman, E. B. 2009. Toward an understanding of the ADHD-trauma connection. *Sexual Abuse,* 20, 359-378.

Loh, J. 2013. Inquiry into issues of trustworthiness and quality in narrative studies: A perspective. *The qualitative report,* 18, 1-15.

Magon, R. & Müller, U. 2012. ADHD with comorbid substance use disorder: review of treatment. *Advances in psychiatric treatment,* 18, 436-446.

Masten, A. S. 2001. Ordinary magic: Resilience processes in development. *American psychologist,* 56, 227.

Maté, G. 2000. *Scattered: How attention deficit disorder originates and what you can do about it*, Penguin.

Matheson, L., Asherson, P., Wong, I. C. K., Hodgkins, P., Setyawan, J., Sasane, R. & Clifford, S. 2013. Adult ADHD patient experiences of impairment, service provision and clinical management in England: a qualitative study. *BMC Health Services Research,* 13, 184-184.

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McAdams, D. P. 2001. The psychology of life stories. *Review of general psychology,* 5, 100.

McAdams, D. P. & McLean, K. C. 2013. Narrative identity. *Current directions in psychological science,* 22, 233-238.

McArdle, P., O'Brien, G. & Kolvin, I. 1995. Hyperactivity: prevalence and relationship with conduct disorder. *Journal of Child Psychology and Psychiatry,* 36, 279-303.

McCarthy, S., Asherson, P., Coghill, D., Hollis, C., Murray, M., Potts, L., Sayal, K., de Soysa, R., Taylor, E. & Williams, T. 2009. Attention-deficit hyperactivity disorder: treatment discontinuation in adolescents and young adults. *The British Journal of Psychiatry,* 194, 273-277.

McGough, J. J. & Barkley, R. A. 2004. Diagnostic controversies in adult attention deficit hyperactivity disorder. *American Journal of Psychiatry,* 161, 1948-1956.

McLeer, S., Deblinger, E., Henry, D. & Orvaschel, H. 1992. Sexually abused children at high risk for post-traumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry,* 31, 875-879.

McLeod, J. 1996. The emerging narrative approach to counselling and psychotherapy. *British Journal of Guidance and Counselling,* 24, 173-184.

McLeod, J. 1997. *Narrative and psychotherapy*, Sage.

McLeod, J. 2011. *Qualitative research in counselling and psychotherapy*, Sage.

McLeod, J. & Balamoutsou, S. 2001. A method for qualitative narrative analysis of psychotherapy transcripts. *Psychological Test and Assessment Modeling,* 43, 128.

Mitchell, S. A. 2014. *Relationality: From attachment to intersubjectivity*, Routledge.

Mitchels, D. B. 2018. *Ethical*

Guidelines for Research in the Counselling Professions [Online]. British Association for Counselling and Psychotherapy. Available: https://www.bacp.co.uk/events-and-resources/research/publications/ethical-guidelines-for-research-in-the-counselling-professions/ [Accessed August 15 2018].

Modesto-Lowe, V., Danforth, J. S. & Brooks, D. 2008. ADHD: does parenting style matter? *Clinical pediatrics,* 47, 865-872.

Mollon, P. 2001. *Releasing the self: The healing legacy of Heinz Kohut*, Whurr Publishers.

Mollon, P. 2015. *The Disintegrating Self: Psychotherapy of Adult ADHD, Autistic Spectrum, and Somato-psychic Disorders*, Karnac Books.

Moncrieff, J. & Timimi, S. 2011. Critical analysis of the concept of adult attention-deficit hyperactivity disorder. *The Psychiatrist,* 35, 334-338.

Moncrieff, J. & Timimi, S. 2013. The social and cultural construction of psychiatric knowledge: an analysis of NICE guidelines on depression and ADHD. *Anthropology & medicine,* 20, 59-71.

Morrow, S. L. 2005. Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology,* 52, 250.

Mueller, A. K., Fuermaier, A. B., Koerts, J. & Tucha, L. 2012. Stigma in attention deficit hyperactivity disorder. *ADHD attention deficit and hyperactivity disorders,* 4, 101-114.

Nadeau, K. G. 2002. The clinician's role in the treatment of ADHD. *Clinicians' guide to adult ADHD: Assessment and intervention.* San Diego, CA, US: Academic Press.

Nehlin, C., Nyberg, F. & Öster, C. 2015. The patient's perspective on the link between ADHD

and substance use: a qualitative interview study. *Journal of attention disorders,* 19**,** 343-350.

Newhill, C. E., Safran, J. D. & Muran, J. C. 2003. *Negotiating the therapeutic alliance: A relational treatment guide*, Guilford Press.

NICE. 2008. *Clinical ADHD Guideline (CG72)* [Online]. Available: https://www.nice.org.uk/guidance/cg72 [Accessed April 25 2015].

NICE. 2018. *NICE ADHD Guideline (NG87)* [Online]. Available: https://www.nice.org.uk/guidance/NG87 [Accessed April 24 2018].

Nigg, J. T. 2018. Toward an emerging paradigm for understanding attention-deficit/hyperactivity disorder and other neurodevelopmental, mental, and behavioral disorders: Environmental risks and epigenetic associations. *JAMA Pediatrics*.

NIMH. *Attention Deficit Hyperactivity Disorder* [Online]. US: National Institute of Mental Health. Available: https://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml#part_145449 [Accessed 23 May 2018].

Norcross, J. C. & Wampold, B. E. 2011. Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy,* 48**,** 98.

Nutt, D., Fone, K., Asherson, P., Bramble, D., Hill, P., Matthews, K., Morris, K., Santosh, P., Sonuga-Barke, E. & Taylor, E. 2007. Evidence-based guidelines for management of attention-deficit/hyperactivity disorder in adolescents in transition to adult services and in adults: recommendations from the British Association for Psychopharmacology. *Journal of Psychopharmacology,* 21**,** 10-41.

Olson, S. L., Bates, J. E. & Bayles, K. 1990. Early antecedents of childhood impulsivity: The role of parent-child interaction, cognitive competence, and temperament. *Journal of Abnormal Child Psychology,* 18**,** 317-334.

Panksepp, J. 2001. The long-term psychobiological consequences of infant emotions: Prescriptions for the twenty-first century. *Neuropsychoanalysis,* 3**,** 149-178.

Pao, P.-N. 1979. Schizophrenic disorders. *Int. Univ. Press, New York*.

Pearlman, L. A. & Courtois, C. A. 2005. Clinical applications of the attachment framework: Relational treatment of complex trauma. *Journal of traumatic stress,* 18**,** 449-459.

Peters, K. & Jackson, D. 2009. Mothers' experiences of parenting a child with attention deficit hyperactivity disorder. *Journal of Advanced Nursing,* 65**,** 62-71.

Peterson, B. S., Pine, D. S., Cohen, P. & Brook, J. S. 2001. Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child & Adolescent Psychiatry,* 40**,** 685-695.

Philipsen, A., Richter, H., Peters, J., Alm, B., Sobanski, E., Colla, M., Münzebrock, M., Scheel, C., Jacob, C. & Perlov, E. 2007. Structured group psychotherapy in adults with attention deficit hyperactivity disorder: results of an open multicentre study. *The Journal of nervous and mental disease,* 195**,** 1013-1019.

Polkinghorne, D. E. 2005. Language and meaning: Data collection in qualitative research. *Journal of counseling psychology,* 52**,** 137.

Ponnou, S. & Gonon, F. 2017. How French media have portrayed ADHD to the lay public and to social workers. *International journal of qualitative studies on health and well-being,*

12**,** 1298244.

Ramsay, J. R. & Rostain, A. L. 2005. Adapting Psychotherapy to Meet the Needs of Adults With Attention-Deficit/Hyperactivity Disorder. *Psychotherapy: Theory, Research, Practice, Training,* 42**,** 72.

Review, W. P. 2018. *London Population* [Online]. Available: http://worldpopulationreview.com/world-cities/london-population/ [Accessed June 11 2018].

Rowland, A. S., Lesesne, C. A. & Abramowitz, A. J. 2002. The epidemiology of attention-deficit/hyperactivity disorder (ADHD): a public health view. *Mental retardation and developmental disabilities research reviews,* 8**,** 162-170.

Sarrami Foroushani, P. 2009. *Exploring variation in clinicians' perception and approach towards adults with ADHD.* University of Nottingham.

Schneider, M., Retz, W., Coogan, A., Thome, J. & Rösler, M. 2006. Anatomical and functional brain imaging in adult attention-deficit/hyperactivity disorder (ADHD)—a neurological view. *European archives of psychiatry and clinical neuroscience,* 256**,** i32-i41.

Scholtens, S., Rydell, A.-M., Bohlin, G. & Thorell, L. B. 2014. ADHD symptoms and attachment representations: considering the role of conduct problems, cognitive deficits and narrative responses in non-attachment-related story stems. *Journal of abnormal child psychology,* 42**,** 1033-1042.

Schore, A. N. 2002. Advances in neuropsychoanalysis, attachment theory, and trauma research: Implications for self psychology. *Psychoanalytic Inquiry,* 22**,** 433-484.

Schore, A. N. 2015. *Affect regulation and the origin of the self: The neurobiology of emotional development*, Routledge.

Schrevel, S. J., Dedding, C., Aken, J. A. & Broerse, J. E. 2016. 'Do I need to become someone else?'A qualitative exploratory study into the experiences and needs of adults with ADHD. *Health Expectations,* 19**,** 39-48.

Schweitzer, J. B., Faber, T. L., Grafton, S. T., Tune, L. E., Hoffman, J. M. & Kilts, C. D. 2000. Alterations in the functional anatomy of working memory in adult attention deficit hyperactivity disorder. *American Journal of Psychiatry,* 157**,** 278-280.

Seidman, I. 2013. *Interviewing as qualitative research: A guide for researchers in education and the social sciences*, Teachers college press.

Shedler, J. 2010. The efficacy of psychodynamic psychotherapy. *American psychologist,* 65**,** 98.

Siegel, D. J. 1999. *The developing mind*, Guilford Press New York.

Silberman, S. 2015. Neurotribes: The legacy of autism and how to think differently about people who think differently. Penguin.

Sims-Schouten, W., Riley, S. C. & Willig, C. 2007. Critical realism in discourse analysis: A presentation of a systematic method of analysis using women's talk of motherhood, childcare and female employment as an example. *Theory & Psychology,* 17**,** 101-124.

Smith, B. 2016. Narrative analysis. *Analysing qualitative data in psychology,* 2**,** 202-221.

Stark, C. 1998. Ethics in the research context: Misinterpretations and misplaced misgivings. *Canadian Psychology/Psychologie canadienne,* 39**,** 202.

Stern, D. N. 1985. *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*, Karnac Books.

Still, G. F. 1902. Some abnormal psychical conditions in children. *Lancet*.

Strathearn, L. 2018. Exploring the neurobiology of attachment. *Developmental science and psychoanalysis.* Routledge.

Sugarman, A. 2006. Attention deficit hyperactivity disorder and trauma. *The International Journal of Psychoanalysis,* 87**,** 237-241.

Tattersall, R. 2002. The expert patient: a new approach to chronic disease management for the twenty-first century. *Clinical Medicine,* 2**,** 227-229.

Thibault, R. T., Veissière, S., Olsona, J. A. & Raz, A. 2018. Treating ADHD with Suggestion.

Timimi, S. 2009. A critique of the neurodevelopmental model of attention deficit hyperactivity disorder. *Thymos: The Journal of Boyhood Studies,* 3**,** 139-144.

Tolin, D. F. & Villavicencio, A. 2011. Inattention, but not OCD, predicts the core features of Hoarding Disorder. *Behaviour Research and Therapy,* 49**,** 120-125.

van der Kolk, B. 1996. The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In van der Kolk, B., McFarlane, A., Weisaeth, L. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society***,** 214-241.

Wallin, D. J. 2007. *Attachment in psychotherapy*, Guilford press.

Wehmeier, P. M., Schacht, A. & Barkley, R. A. 2010. Social and emotional impairment in children and adolescents with ADHD and the impact on quality of life. *Journal of Adolescent Health,* 46**,** 209-217.

White, H. A. & Shah, P. 2006. Uninhibited imaginations: creativity in adults with attention-deficit/hyperactivity disorder. *Personality and individual differences,* 40**,** 1121-1131.

White, H. A. & Shah, P. 2011. Creative style and achievement in adults with attention-deficit/hyperactivity disorder. *Personality and Individual Differences,* 50**,** 673-677.

WHO 1992. *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*, World Health Organization.

Willig, C. 2012. *Qualitative interpretation and analysis in psychology*, McGraw-Hill Education (UK).

Winnicott, D. 1989a/1967. The Concept of Clinical Regression Compared with
that of Defence Organisation. *Psycho-Analytic Explorations***,** pp 193-199.

Witztum, E., Van der Hart, O. & Friedman, B. 1988. The use of metaphors in psychotherapy. *Journal of Contemporary Psychotherapy,* 18**,** 270-290.

Wood, D. R., Reimherr, F. W., Wender, P. H. & Johnson, G. E. 1976. Diagnosis and treatment of minimal brain dysfunction in adults: a preliminary report. *Archives of General Psychiatry,* 33**,** 1453-1460.

Young, S. 2001. The persistence of ADHD into adulthood. *Practice nursing,* 12**,** 453-456.

Young, S. & Bramham, J. 2007. *ADHD in adults: A psychological guide to practice*, John Wiley & Sons.

Young, S., Bramham, J., Gray, K. & Rose, E. 2008. The experience of receiving a diagnosis and treatment of ADHD in adulthood: a qualitative study of clinically referred patients using interpretative phenomenological analysis. *Journal of Attention Disorders,* 11**,**

493-503.

Young, S. & Thome, J. 2011. ADHD and offenders. *The World Journal of Biological Psychiatry,* 12**,** 124-128.

Appendices

Appendix 1 – Recruitment notice (email)

RECRUITMENT NOTICE (EMAIL)

Dear (Organization/Organization Representative/GP/Psychiatrist/Practice Manager),

My name is Siona Bastable and I am a Doctor of Counselling Psychology and Psychotherapy (DCPsych) student at the Metanoia Institute/Middlesex University. My research project is focusing on the stories of adults diagnosed with Attention Deficit Hyperactivity 'disorder'.

Currently, I am looking for volunteers to participate in my dissertation study. All responses to my study are anonymous and ethical approval was granted for this project.

Volunteers will be asked to participate in 3 interviews of approximately 1 hour each. Location, dates and times will be mutually agreed upon with the convenience of the participant in mind.

If you, or someone you know, wish to take part, please reply or have them reply to this email saying "I am interested in taking part in the study" or similar. You will then receive an information sheet and consent form.

Thank you very much for your interest in the study!

Appendix **2** – Ethics Approval Letter

METANOIA INSTITUTE

13 North Common Road
Ealing, London W5 2QB
Telephone: 020 8579 2505
Facsimile: 020 8832 3070
www.metanoia.ac.uk

Siona Bastable
DCPsych programme
Metanoia Institute

23rd April 2015

Ref: *11/14-15*

Dear Siona

Re: Focusing on the Voices of Adults Diagnosed with 'Attention-Deficit-Hyperactivity Disorder'

I am pleased to let you know that the above project has been granted ethical approval by Metanoia Institute Research Ethics Committee. If in the course of carrying out the project there are any new developments that may have ethical implications, please inform me as DCPsych representative for the Metanoia Institute Research Ethics Committee.

Yours sincerely,

Dr Patricia Moran
Research Subject Specialist, DCPsych Programme
Faculty of Applied Research and Clinical Practice

On behalf of Metanoia Institute Research Ethics Committee

Registered in England at the
above address No. 2918520

Registered Charity No. 1050175

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University
London

INTERVIEW SCHEDULE

As the point of narrative inquiry is to allow the narrator to tell their story as freely as possible, research questions are designed to be open-ended and not formally structured.

The kinds of questions used that may be helpful to prompt the narrator or help him or her enter more deeply into their story include the following:

What does 'Attention Deficit Hyperactivity 'disorder'' ('ADHD') mean to you?

What is your personal story of 'ADHD'?
    a) What stands out for you?

How would you describe your experience of 'ADHD'?
    a) At school
    b) In your family
    c) At work
    d) In relationships

What would you like other people to know about 'ADHD'?

What would have helped you?

Appendix 4 – Sample Analysis Page

TEMPORAL Continuity Past, present, future	CONTEXT Place Situation	SOCIALITY	RELATIONALITY
EDWARD – STORY 1			
First mention – used to dictate everything '...so it took me a while to discover there's just nobody available to do that sort of thing anymore.' 'And so I was already thinking back over the past before...I got the assessment. So I went to him (GP counsellor) and he said,'Well, tell me how you feel?' I'm not sure if I'd gone on to ADHD by them. I had but I was trying to explain where all this had come from and why I was like I was. And he just laughed and he said, 'Yeah, but tell me how you feel.' I couldn't answer that question, I had to go away and look it up in the dictionary to think, why can't I explain how I feel? I didn't really know where to start. So I	Brought up in London Has one sister, three years older. As teenagers thought their mother was 'totally self-centred and selfish'. Failed 11-plus exams – headmaster felt he had what it took and could not understand why he failed. Got sent to a school 'where they crammed you with work' 'So I worked very hard but got myself a bad reputation.' Junior in his profession – in time of reel to reel tape recorders Diagnosed at 60 In 2015	'I suffered a lot because of losing the children.' '...somebody commented once that I was a damaged person which kind of surprised us both. Because I never dreamt of ever losing them.' 'I'd always imagined being a father and family life and suddenly I was a father without the family life.' 'That's quite hard, just to get help for depression.' (GP taking it seriously enough to give him some antidepressants. Affair 'knocked me sideways and launched me into depression and the process of going through divorce and then family stuff,	I am already seeing the impact of the there and then on the here and now... Commonalities of ADHD found in early school performance with its difficulties brought by focus and distractibility issues. Feel his sense of loss Helpfulness of structure for Edward Not knowing his own feelings (matches my feeling he is engaged in his own project now of growing his self-awareness) Difficulties being heard I am feeling already a bit 'talked at'l

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Adult 'ADHD' Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity 'disorder' ('ADHD').

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with 'ADHD'. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.

2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with 'ADHD' in adults and further investigation is warranted.

3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the 'disorder' and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

2. Consider work/school, social and family settings.

3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have 'ADHD' need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.			Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?							
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?							
3. How often do you have problems remembering appointments or obligations?							
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?							
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?							
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?							
							Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?							
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?							
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?							
10. How often do you misplace or have difficulty finding things at home or at work?							
11. How often are you distracted by activity or noise around you?							
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?							
13. How often do you feel restless or fidgety?							
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?							
15. How often do you find yourself talking too much when you are in social situations?							
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?							
17. How often do you have difficulty waiting your turn in situations when turn taking is required?							
18. How often do you interrupt others when they are busy?							
							Part B

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The Value of Screening for Adults With 'ADHD'

Research suggests that the symptoms of 'ADHD' can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it.[1-4] Because this 'disorder' is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult 'ADHD' Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult 'ADHD' that included the following team of psychiatrists and researchers:

- **Lenard Adler, MD**
  Associate Professor of Psychiatry and Neurology
  New York University Medical School

- **Ronald C. Kessler, PhD**
  Professor, Department of Health Care Policy
  Harvard Medical School

- **Thomas Spencer, MD**
  Associate Professor of Psychiatry
  Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for 'ADHD' in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of 'ADHD' symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis.[4]

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:
1. Schweitzer JB, et al. Med Clin North Am. 2001;85(3):10-11, 757-777.
2. Barkley RA. Attention Deficit Hyperactivity 'disorder': A Handbook for Diagnosis and Treatment. 2nd ed. 1998.
3. Biederman J, et al. Am J Psychiatry. 1993;150:1792-1798.
4. American Psychiatric Association: Diagnostic and Statistical Manual of Mental 'disorder's, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000: 85-93.

Appendix 6 - List of behaviours associated with adult 'ADHD'

DSM-5

➢ Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

➢ Often has trouble keeping attention on tasks or play activities.

➢ Often does not seem to listen when spoken to directly.

➢ Often does not follow instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behaviour or failure to understand instructions).

➢ Often has trouble organizing activities.

➢ Often avoids, dislikes, or doesn't want to do things that take a lot of mental effort for a long period (such as schoolwork or homework).

➢ Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).

➢ Is often easily distracted.

➢ Is often forgetful in daily activities

Others

❖ Spending a lot of time on a task, but never seeming able to complete it.

❖ When with loved ones, feeling distracted and having trouble listening to them.

❖ Having a child or parent with either the symptoms or diagnosis of 'ADHD'.

❖ Having difficulty stopping talking out of turn.

❖ Interrupting others, even when they are occupied or busy.

❖ Unable to relax.

❖ If a project looks like it will need vigilant mental effort, delaying or avoiding starting it until the last minute.

❖ Always being late for things.

❖ Forgetting where things have been put.

❖ Losing attention when someone is speaking.

❖ Hesitation to sustain concentration in planning and organizing for the completion of tasks

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- ❖ Hesitative responses, doubt, and delayed execution due to inattention remembering information

- ❖ Difficulty finishing projects or completing assignments because many tasks simultaneously on the go

- ❖ Forgetting to complete tasks and details after temporarily switching to more stimulating tasks

- ❖ Difficulty finding misplaced tools after task switching due to bypassing adequate memory storage

- ❖ Sustained information processing is slower than others causing information gaps that inhibit execution

- ❖ Problems remembering appointments, obligations, or instructions

- ❖ Difficulty learning new projects when concentration deficits cause desire to multitask or daydream

- ❖ Distracted from persevering during work; difficulty holding onto a job for a significant amount of time

- ❖ Change plans to the inconvenience of others due to forgetting or not fully aware of the bigger scenario

- ❖ Maintaining excessive personal items such as storing old items of diminished usefulness

- ❖ Obsessive behaviour as compensation or coping mechanism for a perseverance deficit

- ❖ Difficulty transitioning to new task or activity due to obsessive behaviour

- ❖ Higher rate of vigilant concentration fatigue after inhibiting many distractions from greater effort required

Appendix 7 - Resources for practical strategies to manage 'ADHD' behaviours

ADHD in Adults: A Psychological Guide to Practice (1996), Susan Young and Jessica Bramham, Wiley

The Adult Attention Deficit Disorders Intervention Manual (1997), Michele T. Jackson, M.Ed., Hawthorne Educational Services, Inc. US

The Adult ADHD Treatment Handbook (2018), Anne Jeavons, Tara Bishop, Blandine French and Siona Bastable, Routledge

Tables

Table 1 - Participant Details

Name	Sex	Age	Occupation	Diagnosed	Medication	Diagnosis
Harry	Male	30	Political Analyst	29	Effective	Self/GP
Joe	Male	48	Entrepreneur	45	Partially effective	Self/GP
Edward	Male	61	Unemployed/Entrepreneur	60	Not effective	Self/Others
Sarah	Female	54	Part-time Teacher	50	Effective but blood pressure risk	Children/Self/GP
Heidi	Female	48	Nurse Director	42	Effective	Children/Others/GP
Huw	Male	58	Retired/Volunteer	54	Effective	Self/GP

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Table 2 – Therapeutic Guidelines

Therapeutic Guidelines	
Formulation	*Note the somatic markers of 'ADHD', also academic, occupational and relational evidence of failure despite capacity and/or intention.*
Time management	*Allow for a compromised relationship with time. Offer to send reminders for sessions but respect the client's desire to manage this in their own way*
'Feeling felt'	*Recognise and validate the ADHD client's internal and external reality through active listening*
Differentiate between the self and the 'ADHD'	*Work with the client to identify the difference between who they are and their behaviours*
Subjective and objective selves	*Work to establish better internal boundaries for the subjective self while reducing the impact of an objective self that has been informed by a critical outside world*
Being heard and seen	*Use of empathy and introspection to support and reframe a client's perceptions of self and others*
Self-regulation	*Draw attention to the physiological and unconscious processes of anxiety*
Avoiding overwhelm	*Working with the client to identify and attend to their somatic markers to access and apply stress reducing steps*
Making the invisible visible	*Identify the client's manifestation of 'ADHD' – and work with them to identify strengths and weaknesses*
Clinical use of language	*Metaphors and imagery can be used to deactivate client defences and reframe what have formerly been perceived as deficits*
Behaviour modification	*Be knowledgeable and prepared to use coaching strategies occasionally to help a client manage their 'ADHD' behaviours*

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