Examining Strength-Based Characteristics in Adults with ADHD

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Blu - My cat, my fluffy nemesis, my emotional support saboteur. In moments of hyperfocus where time dissolved and my spine fused into my desk chair, it was your disheartened meows and accusatory stares that pulled me back to reality. Thank you for reminding me - often loudly - that no thesis is more important than food and attention. You kept me tethered, whether I liked it or not.

To myself - Because if there's one thing we're good at in this profession, it's *telling* others to practise self-compassion while quietly falling apart behind the scenes. So, this is me walking the talk.

To the version of me who gave up weekends, plans, and a *very* busy social life - thank you. For sticking with it when it got messy, for laughing through the chaos, and for still showing up with curiosity, humour, and more tabs open than SPSS could handle. I don't say this often enough, but I'm proud of you.

GLOSSARY OF TERMINOLOGY

Definitions and explanations of key terminology are provided throughout the thesis. Some terms, including 'strengths', 'identity', and 'neurodiversity', are conceptually complex and can be understood in different ways depending on the context. These meanings may vary across clinical, academic, and lived-experience perspectives. For this reason, a glossary is included to clarify how such terms are used within this research. The definitions presented here are not intended to be universal or exhaustive. Instead, they provide a foundation for clarity while engaging with this thesis.

Strengths (in ADHD): Refers to positive attributes, abilities, or traits that individuals associate with their ADHD, such as creativity, adaptability, hyperfocus, or divergent thinking. In this thesis, 'strengths' are not defined as objective, measurable talents, but as self-perceived qualities that hold personal or functional value, particularly in the context of navigating a world that often pathologises difference.

Self-Concept: A person's internal understanding and evaluation of who they are, encompassing beliefs about one's traits, capabilities, and identity. Here, self-concept is viewed as dynamic and socially shaped, particularly sensitive to diagnosis, societal messages, and the 'mirrors' provided by others.

Neurodiversity: A framework that recognises neurological differences such as ADHD, autism, and dyslexia as natural variations of human cognition, rather than pathologies. This thesis adopts a neurodiversity-affirmative stance, viewing ADHD through a lens of difference rather than disorder, while also acknowledging the real-world challenges that come with being neurodivergent in a neurotypical world.

Adult ADHD: Used to describe individuals diagnosed with ADHD in adulthood, or who continue to meet diagnostic criteria beyond childhood. This distinction matters because the experience of 'becoming' ADHD through a late diagnosis may shape self-concept differently than in those diagnosed earlier.

Strengths-Based Approach: A clinical and research orientation that centres individuals' assets, capabilities, and potential, rather than focusing solely on symptoms or deficits. In this thesis, a strengths-based approach is used both methodologically (in the development of the ASIQ) and conceptually (in reframing how ADHD identity is understood).

Deprivation (Index of Multiple Deprivation - IMD):
Refers to socioeconomic disadvantage, as measured using UK-wide city-based indicators across domains like income, employment, and education. In this thesis, deprivation is not treated as a direct proxy for poverty, but rather as a contextual factor that may influence how individuals with ADHD perceive and express their strengths.

Diagnosis (in ADHD): Used here to refer not just to the clinical act of receiving a label, but as a process of identity transformation that can carry both validating and stigmatising effects. This thesis considers diagnosis as a social and psychological event, not merely a clinical endpoint.

Lived Experience: Refers to the personal, subjective experience of having ADHD, particularly as narrated by individuals themselves. Lived experience is central to this study's rationale and is treated as a valid and critical source of insight, particularly in the development of the ASIQ.

ABSTRACT

Aim: To explore strengths-based self-concept in adults diagnosed with ADHD and to develop and conduct a preliminary psychometric evaluation of a novel self-report measure of self-perceived ADHD-related strengths (the ADHD Strengths Identification Questionnaire; ASIQ).

Method: A novel self-report measure, the ASIQ, was developed based on a synthesis of qualitative literature and expert feedback from adults with ADHD. Data were collected via an online survey from 167 adults with a formal ADHD diagnosis. Exploratory factor analysis (EFA) was employed to establish the factor structure and internal consistency of the ASIQ. Independent samples t-tests, ANOVAs, and ordinal regression analyses assessed the relationship between strength identification and demographic variables including gender, education, socioeconomic deprivation, and ADHD treatment history.

Results: EFA supported a two-factor, 12-item solution: Cognitive Adaptability and Creative–Divergent Thinking, with acceptable preliminary internal consistency. Descriptively, participants reported moderate-to-high endorsement of strengths across both domains. In univariable analyses, Creative–Divergent Thinking differed by gender and Cognitive Adaptability differed by educational attainment; deprivation and treatment history were not significantly associated with ASIQ scores. In combined models, demographic predictors were not statistically significant, suggesting that any subgroup effects were modest and should be interpreted cautiously.

Discussion: These findings provide preliminary empirical support for the idea that adults with ADHD recognise positive strengths associated with their condition. The two-factor structure of the ASIQ mirrors themes from previous qualitative studies, suggesting a convergence between lived experiences and measurable strengths domains. Gender and education differences emerged in strength endorsement, though these results should be interpreted cautiously due to sample imbalances. Importantly, this research is in an early, exploratory stage - the ASIQ is not yet ready for clinical use. Nonetheless, the work highlights the potential value of strengths-based approaches in ADHD. Integrating an awareness of cognitive adaptability and creative-divergent thinking into post-diagnostic support and therapy could help adults with ADHD develop a more balanced and positive self-concept. Future research will need to validate the ASIQ through further psychometric testing

(e.g. confirmatory factor analysis, broader samples) and establish how these strength domains relate to real-life outcomes. This initial evidence, however, underscores that viewing ADHD through a dual lens of challenges *and* strengths can enrich clinical practice and research, aligning with neurodiversity-affirmative perspectives.

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Prologue

Imagine an alien observing Earth, intrigued by how humans navigate their world.

Some people immerse themselves in a single task for hours, while others leap between ideas, fuelled by bursts of energy and curiosity. From this alien's perspective, neither approach is superior - they are simply different modes of human cognition. The notion of 'disorder' does not exist in their lexicon; there is only variation.

This thought experiment invites a question: what if difference is not inherently pathological? What if the problem lies not within the individual, but in the world that interprets their difference through a narrow lens?

While this metaphor of the alien may seem whimsical, it captures something fundamentally human: the experience of navigating the world with a cognitive style that often feels at odds with its design. For many individuals with ADHD, especially in adulthood, there is a persistent sense of misalignment - not due to deficiency, but difference. The thesis will explore how this sense of 'otherness' has been historically constructed through deficit-based narratives, and how emerging perspectives are beginning to shift the focus towards strength, adaptability, and potential.

1.2 Epistemological Stance and Researcher Positionality

This research is grounded in a dual epistemological stance: critical realism and social constructionism. Critical realism acknowledges that neurodevelopmental traits like ADHD may have biological foundations, but that our understanding of these traits is mediated through culture, language, and social context (Bhaskar, 1978). Difficulty concentrating, for example, is not an objective deficit until it is defined as such within a society that values prolonged attention. Social constructionism complements this by focusing on how identities are shaped through discourse and interaction. ADHD, in this view, is not simply a biological fact but a socially constructed identity - one defined by diagnostic criteria, institutional practices, public attitudes, and personal meaning-making (Canu et al., 2008). This stance encourages a more nuanced exploration of ADHD that considers not only what it is, but what it means.

As the researcher, I write from an insider perspective: I am an adult with ADHD. This positionality has shaped my engagement with the topic. Like many, I once internalised the dominant narrative - seeing myself as disorganised, undisciplined, and defective. My diagnosis brought a profound sense of clarity, and over time I began to reinterpret those same traits as part of a valuable and distinctive identity. Traits that once brought shame - hyperfocus, emotional intensity, non-linear thinking - became sources of creativity, connection, and professional direction.

This journey from self-doubt to self-acceptance fuels the present research. My insider status has fostered empathy and sensitivity to the nuances of ADHD identity, while also requiring constant reflexivity to mitigate bias. I have aimed to balance personal insight with rigorous inquiry - grounding interpretations in the literature and remaining open to perspectives that differ from my own.

1.3 ADHD in Adulthood

1.3.1 Historical and Clinical Overview

ADHD has long been recognised as a neurodevelopmental condition of childhood onset, characterised by inattention, hyperactivity, and impulsivity (Barkley, 2006). While early descriptions of such behaviour date back over a century, formal diagnostic recognition only took shape in the latter part of the 20th century, with initial emphasis placed on children (Smith, 2012). For years, prevailing wisdom held that ADHD symptoms faded with adolescence. However, longitudinal research has overturned this assumption, showing that ADHD frequently endures into adulthood (Blais et al., 2016). By the early 2000s, consensus statements - including the NIH ('Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD).', 1998) conference in 1998 and international guidelines in 2002 (Biederman, 2017) - firmly recognised ADHD as a legitimate, lifelong condition with neurobiological roots and significant psychosocial consequences.

This evolving understanding has coincided with a sharp increase in adult ADHD diagnoses and treatment in the UK. According to NHS data, the percentage of patients diagnosed with ADHD nearly doubled between 2017-18 and 2022-23, reflecting growing recognition and medicalisation of the condition in adulthood (*NHS England, 2023*). Research indicates that this trend reflects both growing awareness and decades of under-recognition (Asherson et al., 2022). Several factors have contributed to this rise: increasing mental health literacy in the general public, updated clinical guidelines recognising adult ADHD (e.g. NICE, 2018), and longitudinal research showing that symptoms often persist into adulthood (Blais et al., 2016). Many adults, previously undiagnosed due to restrictive childhood-only criteria in earlier diagnostic systems such as ICD-10, have come to identify their lifelong difficulties through this newer lens (Kooij et al., 2010). In addition, revisions to diagnostic frameworks such as the DSM-5 have expanded the criteria for adult ADHD, allowing for

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later symptom onset and fewer required symptoms, thereby enabling more individuals to meet the clinical threshold. The neurodiversity movement has also helped to reframe ADHD as a legitimate and valid form of cognitive difference, encouraging more people to seek assessment (Rosqvist et al., 2023). The increasing visibility of adult ADHD has led to a surge in referrals and diagnoses, often in mid-life; for example, Scotland saw a 1,000% increase in adult ADHD referrals between 2020 and 2023, highlighting growing recognition and unmet need (Marron & McKeown, 2024). This backdrop forms a key rationale for the present thesis: to understand how such a late-emerging diagnosis shapes adults' sense of identity and self-worth.

Epidemiological studies estimate that 5-7% of children worldwide meet ADHD criteria (Simon et al., 2009), and of these, at least two-thirds continue to experience impairing symptoms into adulthood. Global adult prevalence is estimated at 2-3%, which in the UK equates to hundreds of thousands - possibly over a million - adults living with ADHD (Kessler et al., 2006a). Historically, this group was largely invisible. Diagnostic systems such as ICD-10 restricted adult diagnosis to those with documented childhood symptoms, excluding many who did not receive assessment as children (Trott, 2006). Recent revisions to diagnostic criteria, however, have addressed these limitations: the required number of symptoms for adults has been lowered, the age of onset has been raised from 7 to 12 years, and co-diagnosis with autism - previously prohibited - is now permitted (Prosser & Reid, 2013). As a result, many adults who previously fell through the diagnostic net are now able to access recognition and support.

Clinically, adult ADHD manifests somewhat differently from childhood presentations. Rather than visible hyperactivity, adults often report chronic distractibility, disorganisation, emotional dysregulation, and internal restlessness (Knouse et al., 2009; Weibel et al., 2021). Despite this subtler presentation, the condition is associated with significant impairment

across life domains - including employment, education, and relationships (Antshel et al., 2014; Barkley & Brown, 2008). Psychiatric comorbidities are the norm rather than the exception: anxiety, depression, substance misuse, and personality disorders are common, with some studies reporting comorbidity rates exceeding 80% (Asherson et al., 2022).

Unmanaged ADHD in adulthood can have far-reaching consequences. Adults with ADHD are more likely to experience academic underachievement, employment instability, financial problems, and interpersonal conflict (Lee, 2020). There is also an elevated risk of adverse outcomes such as accidents, poor physical health, and reduced quality of life (Quintero et al., 2019). Importantly, these outcomes are not merely the result of core symptoms, but may reflect the cascading impact of years of misunderstood struggles. The "restless child," rarely accommodated, becomes the overwhelmed adult - still navigating a world that was never designed for their mind (Young et al., 2019). While these effects are likely to be shaped by more than neurobiology alone, including the influence of educational, clinical, and societal systems, the full extent and interplay of these factors remains under-researched, and conclusions must be drawn with caution (Tegtmejer, 2018).

1.3.2 ADHD in the UK: Clinical, Policy, and Service Context

In the UK, the recognition of adult ADHD has increased markedly over the past two decades, yet the development of corresponding services has lagged behind. Epidemiological data suggest that approximately 2-3% of adults meet diagnostic criteria (Kessler et al., 2006b), but historically, most remained undiagnosed due to the restrictive nature of ICD-10 criteria and a lack of awareness among clinicians (Jousselin, 2018). This began to shift following the publication of NICE Guideline CG72, which formalised assessment and treatment pathways for adults (Dalrymple et al., 2020). Revisions to diagnostic criteria, such as raising the age of symptom onset and reducing the number of required symptoms in adulthood, have further widened access to diagnosis. Since then, adult ADHD prescriptions in

England have increased dramatically; for example, prescriptions for men aged 18-29 rose nearly fiftyfold between 2000 and 2018 (McKechnie et al., 2023).

However, the infrastructure has struggled to cope with this demand. Specialist services remain scarce and inconsistently distributed, with significant regional gaps. A national survey by Price et al., (2020) identified only 44 dedicated NHS services for adults with ADHD, of which fewer than a third offered the full range of NICE-recommended treatments, including psychological therapies and transitional support. Stakeholders reported wide variation in service awareness and access, with many adults encountering barriers at the point of referral, especially when transitioning from child to adult services (Eke et al., 2020).

Ethnographic research by (Jousselin, 2018) highlights systemic tensions between the clinical needs of ADHD patients and bureaucratic imperatives within the NHS. Drawing on observations from a single specialist adult ADHD service over a decade ago, the study documented how long waiting times, strict referral criteria, and DNA (Did Not Attend) policies could inadvertently penalise individuals for the very symptoms-forgetfulness, disorganisation-they were seeking help for. Administrative staff were often left to absorb this burden of care, 'holding' patients during prolonged waiting periods through reminder calls and flexible scheduling. While these insights remain valuable, they reflect the practices of one particular service at a specific point in time, and may not fully capture how adult ADHD care has evolved nationally in recent years. Nonetheless, they raise enduring questions about the fragility of support systems and the unintended consequences of policies aimed at efficiency-questions that remain relevant as services continue to adapt and expand.

Where adult ADHD services do exist, they are often highly medicalised, with medication management dominating provision (Price et al., 2020). Access to psychological interventions, strengths-based support, or structured post-diagnostic care remains limited, leading many adults to seek private support or turn to peer-led groups (Matheson et al.,

2013). As a result, individuals may receive a diagnosis but little support in understanding or integrating it-a process which has profound implications for self-concept and identity. This shortfall underscores the need for a more holistic approach to ADHD care: one that extends beyond symptom management to address meaning-making, identity, and psychosocial wellbeing in adulthood.

1.3.3 Conceptualising ADHD Through a Deficit Lens

Despite advances in recognising ADHD as a lifespan condition, it remains predominantly framed through a deficit-based lens in diagnostic and clinical settings. Diagnostic manuals such as DSM-5 and ICD-11 define ADHD by reference to impairments and behavioural shortfalls - criteria that focus on what individuals lack compared to normative expectations (APA, 2013). For example, descriptors such as "fails to give close attention" or "often interrupts" implicitly contrast ADHD behaviour with societal ideals of sustained focus, patience, and inhibition. From the outset of the diagnostic process, individuals are asked to recount their failures and functional problems - difficulties concentrating, impulsive errors, disorganisation - reinforcing a pathologising view. This is especially evident in UK NHS pathways, where adult assessments are structured around long interviews and symptom checklists that catalogue impairments (Jousselin, 2018).

The message conveyed is clear: ADHD is a disorder of insufficient self-regulation that must be controlled. While this framing may be necessary to secure diagnosis and access to support, it risks excluding those who experience similar traits but reject the medicalised label, or who find the concept of ADHD itself problematic. These individuals - often positioned outside formal diagnostic systems - are necessarily overlooked by research such as the present study, which relies on diagnosis as an inclusion criterion. This raises important questions about who gets recognised, who is left out, and how the boundaries of ADHD are socially and clinically constructed.

Interventions generally follow suit. Pharmacological treatment, primarily stimulant medication, is typically the first-line recommendation (NICE, 2018). Cognitive-behavioural therapy (CBT) is also widely recommended, often with an emphasis on building compensatory skills to reduce symptoms and improve functional outcomes (Ramsay, 2006). National guidelines echo this orientation: the NICE (2018) guidelines define ADHD as causing "significant impairment" and emphasise early identification and symptom-focused treatment to mitigate adverse outcomes. This stance is not without justification - untreated ADHD has consistently been associated with increased risk of accidents, substance misuse, criminal involvement, and poorer physical and mental health (Asherson et al., 2022; Doshi et al., 2012). Effective treatment, particularly medication, has also been linked to significant reductions in traffic incidents, depressive symptoms, and even premature mortality (Asherson et al., 2022). However, this characterisation of CBT does not represent all clinical approaches. For example, (Dittner et al., 2018) conducted a proof-of-concept trial of individual formulation-based CBT for adults with ADHD, explicitly addressing how early experiences of being misunderstood or unsupported shaped participants' self-beliefs and coping strategies. Although primary outcomes still focused on symptom severity and functioning to facilitate comparison with other treatments, secondary outcomes explicitly included emotional distress, and the intervention itself embraced a neuro-affirmative, strengths-based approach that challenged deficit narratives and encouraged acceptance of ADHD as a cognitive difference rather than merely a disorder (Dittner et al., 2018).

Nonetheless, the prevailing clinical emphasis on impairment and risk, reinforces a narrative where ADHD is considered significant primarily because of the problems it causes. The rationale for intervention, from this perspective, is to alleviate deficits and prevent damage. Consequently, individuals with ADHD are frequently framed as having cognitive shortcomings that impose burdens on themselves, their families, and society. It is important,

however, to recognise that this narrative is actively challenged in some psychological interventions. Services adopting a formulation-driven, neuro-affirmative stance, such as described by Dittner et al. (2018), explicitly help individuals to critically examine and reconstruct their understanding of ADHD, emphasising differences rather than deficits. Nonetheless, this remains relatively uncommon in broader clinical practice, highlighting a tension between traditional deficit-oriented paradigms and emerging strengths-focused approaches.

This deficit model is also shaped by broader socio-political forces. ADHD rose to prominence during a period of expanding medicalisation of behavioural difference, in which increasingly diverse patterns of behaviour were classified as psychiatric conditions (Prosser, 2014). As Timimi & Taylor, (2004) argue, the diagnostic criteria for ADHD reflect not universal truths but culturally specific values. Hyperactivity and distractibility became problematic largely because they conflicted with institutional demands: sitting still in school, performing consistently in 9-to-5 jobs, and regulating behaviour within rigid norms (Lasky et al., 2016)

This medicalised framing locates the "problem" within the individuals' brain, often obscuring the role of context. For example, ADHD traits are situational - many individuals can focus intensely on tasks they find stimulating, yet this nuance is lost when diagnostic criteria flatten such variability (Weisner, 2016). Furthermore, critical perspectives highlight the intersection of ADHD diagnosis with social disadvantage. Factors such as poverty, trauma, and educational inequity can contribute to behaviours that resemble ADHD, but a narrow neurobiological lens risks overlooking these contextual influences (Erlandsson et al., 2022). In their critique, Erlandsson and colleagues argue that the medical model "prohibits a multidimensional approach," masking psychosocial contributors such as emotional stress and systemic inequality.

This framing aligns with a broader neoliberal ethos that prioritises productivity, self-discipline, and personal responsibility. Individuals who struggle to meet these standards are often pathologised and urged to seek intervention. ADHD becomes not just a diagnosis but a mechanism through which society regulates deviation from economic and institutional norms (Lloyd et al., 2006).

Within NHS practice, the impact of this deficit model is evident. Adult ADHD services are typically housed within secondary care and require specialist referrals, resulting in long waiting lists and uneven provision across the UK (Price et al., 2020). Many areas lack dedicated adult ADHD clinics altogether, and general practitioners are often ill-equipped to manage the condition. As of the late 2010s, only a small fraction of adults with ADHD in the UK were receiving appropriate care, a gap that speaks to decades of under-recognition and service fragmentation (Smith et al., 2024).

Efforts are underway to improve access, with policy initiatives encouraging integration of ADHD care into primary settings. Yet the core treatment paradigm remains largely unchanged: locate the deficit, prescribe the remedy. Even where services exist, the focus is often on symptom management rather than supporting identity, building on individual strengths, or exploring the lived meaning of the diagnosis (Schrevel et al., 2016). Medication may improve concentration, and therapy may teach compensatory strategies, but many adults find there is limited space to reflect on who they are with ADHD - beyond what they lack. That said, some services are beginning to challenge this model. For example, Dittner et al. (2018) describe a formulation-based CBT approach that explicitly addresses stigma, emotional distress, and self-concept through a neuro-affirmative and strengths-based lens. While not yet widespread, such approaches point to the potential of more holistic, identity-supportive models of care. To fully appreciate how entrenched this deficit-based lens

has become in clinical thinking, it is helpful to examine the theoretical models that originally shaped it.

The deficit-oriented framing of ADHD is not only embedded in diagnostic criteria and clinical discourse but also rooted in early cognitive theories that sought to explain its neuropsychological basis. One of the most influential is Barkley's (1997) behavioural inhibition theory, which proposed that ADHD arises from a fundamental deficit in the ability to inhibit responses. This core impairment was seen as the gateway through which other executive dysfunctions-such as poor working memory, emotional self-regulation, and goal-directed behaviour-would unfold. This model positioned behavioural inhibition as the linchpin of ADHD-related difficulties, anchoring the condition within a framework of internal control deficits.

Closely aligned with this is the Executive Dysfunction model, which conceptualises ADHD as a disorder of higher-order cognitive processes required for planning, organisation, sustained attention, and problem-solving (Willcutt et al., 2005). These models were critical in legitimising ADHD as a neurodevelopmental disorder, helping to shape neuropsychological assessment tools and treatment rationales. However, their deficit-focused orientation reinforced a pathologising narrative that positioned individuals with ADHD as fundamentally impaired compared to neurotypical norms. While valuable in establishing the condition's neurobiological basis, these theoretical frameworks have had lasting influence on how ADHD is understood, diagnosed, and, crucially, how those diagnosed may come to view themselves.

This deficit-focused conceptualisation has advanced clinical understanding and helped many individuals access support. However, it leaves important questions unanswered. How do adults with ADHD see themselves in light of their diagnosis? Can reframing the condition in more holistic terms - as a form of neurodiversity rather than defect - change the way

people live with it? And might such a shift help individuals construct a more positive and coherent self-concept?

1.4 Theoretical Frameworks for Self-Concept and ADHD

To move beyond a one-dimensional view of ADHD as deficit, it is helpful to consider frameworks that examine how individuals come to understand and construct their sense of self. Three are especially relevant to this thesis: Rogers' psychological self-concept theory, Cooley's sociological notion of the looking-glass self, and Antonovsky's salutogenic theory from health psychology. Each illuminates how people internalise experiences, labels, and social feedback - shaping their identity in both limiting and empowering ways.

1.4.1 Self-Concept Theory and ADHD

Self-concept refers to an individual's perception of who they are - including beliefs, emotions, and narratives about one's own character and capacities. Humanistic psychologists such as Carl Rogers (1959) emphasised that a stable, positive self-concept is vital for well-being. Experiences of success and affirmation tend to support positive self-views, while repeated failure and criticism often erode self-worth.

Adults with ADHD frequently describe a history marked by challenges in school, work, and relationships - settings in which they struggled to meet expectations and often received negative feedback. These repeated experiences can foster internalised beliefs such as "I'm lazy" or "I can't be relied on" (Beaton et al., 2022). Research consistently finds lower self-esteem and self-concept clarity among adults with ADHD compared to neurotypical peers (Pedersen et al., 2024), with higher symptom severity linked to more negative self-evaluations (Zapata & Worrell, 2023). Such internalised negativity can become self-reinforcing, increasing vulnerability to depression, anxiety, and further dysfunction. Indeed,

low self-esteem has been shown to mediate the relationship between ADHD symptoms and broader mental health difficulties (Pedersen et al., 2024).

Yet self-concept is not static. It can shift over time, especially in response to new insights or contexts. Receiving an ADHD diagnosis in adulthood often marks a pivotal moment in personal narrative - one that can reframe years of confusion or shame. For many, the diagnosis provides a long-awaited explanation: "I'm not broken, I have ADHD." Qualitative studies show that this realisation can be profoundly validating, offering self-understanding and emotional relief (Hansson Halleröd et al., 2015). For some, it is a catalyst for self-compassion and reparation.

However, diagnosis can also generate ambivalence. Some adults fear the label implies defectiveness, or worry how others will perceive them. In Hansson Halleröd et al., (2015) study, participants generally welcomed diagnosis, but many also expressed concerns about stigma and the constraints of a diagnostic identity. These findings suggest that self-concept in ADHD is fluid and dynamic, influenced not just by symptoms, but by personal meaning-making and social context.

1.4.2 The "Looking-Glass Self" and Social Mirrors

Sociologist Cooley (1902) proposed that individuals form their self-identity through perceived reflections from others - the "looking-glass self." We imagine how others see us, respond to that perceived view, and internalise it. Over time, these social reflections coalesce into a sense of self.

For adults with ADHD, this theory offers a potent explanation of how negative self-concepts may form and persist. Many have grown up under a cloud of judgement - from teachers labelling them as disruptive, to peers mocking their forgetfulness, to employers criticising their inconsistency. Over time, these repeated reflections - "scatterbrained," "lazy," "irresponsible" - become internalised as identity. This process mirrors what Corrigan &

Shapiro, (2010) describe in their research on self-stigma in mental health, where individuals absorb societal stereotypes, leading to diminished self-esteem and belief in their own efficacy. For people with ADHD, whose difficulties are often misunderstood or trivialised, the psychological toll can be particularly deep. Comments such as "Everyone gets distracted sometimes" or "Stop using ADHD as an excuse" invalidate lived experiences and foster shame (Canu et al., 2008). One study even found adults describing themselves as "less than human" after years of social devaluation (Schoeman & Voges, 2022).

Yet Cooley's framework also suggests a path to repair. Positive mirrors; family members who are understanding, colleagues who accommodate differences, peer groups who share lived experience - can foster healthier self-perceptions. In particular, online communities and support groups have become powerful counter-mirrors. These spaces validate shared struggles and celebrate differences. (Miklósi et al., 2024) for example, found that adults with ADHD who connected with peers often developed a stronger sense of self-worth and were more likely to identify their own strengths.

Returning to our alien observer: in their world, cognitive differences would not be pathologised, they would be accepted as natural variation. Humans, however, rely on reflection from others to define who they are. For adults with ADHD, the social mirrors they encounter can either distort their self-image or help them see themselves more clearly - not as broken, but as differently wired (Godfrey et al., 2020).

1.4.3 Salutogenic and Strengths-Based Perspectives

While clinical discourse has long focused on ADHD's impairments, salutogenic theory offers a complementary framework that emphasises resilience and well-being. Developed by (Antonovsky, 1987), the salutogenic model asks not what causes illness, but what enables people to stay well despite adversity. Its core concept, *sense of coherence*

(SOC), reflects an individual's belief that life is comprehensible, manageable, and meaningful. A strong SOC is linked to greater psychological resilience and adaptive functioning.

Applied to ADHD, a salutogenic approach shifts attention from deficits to the strengths, coping strategies, and environmental supports that allow individuals to thrive. This does not ignore real challenges, but it asks a different question: What enables some adults with ADHD to develop positive self-worth and life satisfaction despite their difficulties? For example, a person with ADHD might be buoyed by a supportive partner, meaningful work, or a creative outlet. These become salutogenic resources that buffer stress and reinforce a positive identity.

Closely aligned with this is the strengths-based perspective, which seeks to identify and cultivate positive traits associated with ADHD. Research in this area is still emerging, but growing evidence suggests that some adults with ADHD perceive their traits as assets in the *right* contexts (Crook & McDowall, 2023). They describe themselves as creative, adventurous, energetic, quick-thinking, or highly focused on tasks of interest (Miklósi et al., 2024). For these individuals, traits often viewed as impairments - such as impulsivity or distractibility - may also underpin spontaneity, curiosity, and original thinking.

A recent thematic analysis by (Nordby et al., 2023) found that many adults with ADHD identified positive attributes linked to their diagnosis. Traits such as empathy, courage, and an openness to experience were frequently mentioned. Some participants saw their outsider status - their sense of being "different" - as having made them more reflective or compassionate. Others viewed their fast-moving minds and energetic temperaments as valuable in dynamic settings. These perspectives do not deny the challenges of ADHD. Instead, they suggest a duality: the same traits that cause difficulty can also be sources of strength. An adult who sees their impulsivity as linked to adventurousness or their

distractibility as a form of creativity may begin to build a more integrated self-concept - one that encompasses both struggle and potential. Salutogenic theory would predict better outcomes for such individuals, as a meaningful and coherent self-understanding helps to counteract negative feedback and internalised stigma.

This shift is echoed in the neurodiversity movement, which regards ADHD not as a defect but as a natural variation in human cognition (Holmquist et al., 2023). Neurodiversity advocates emphasise that conditions like ADHD are part of a broader spectrum of brain-based differences, with both advantages and drawbacks depending on context. In effect, it asks society to move closer to the alien's gaze: to see difference without defaulting to disorder, and to build systems that accommodate a wider range of minds.
Framed in this way, ADHD becomes not merely a disorder to be treated, but a difference to be understood and supported. Neurodiversity-informed care may include not only symptom management but also fostering areas of interest, building confidence, and providing environments that accommodate divergent cognitive styles. Preliminary evidence suggests that incorporating strengths-based dialogue in therapy can improve self-acceptance and promote more balanced self-concepts (Chapman & Botha, 2023).

Together, salutogenic and neurodiversity-informed perspectives invite a richer view of adult ADHD - one that acknowledges vulnerability but also values the unique capacities that may accompany the condition. This echoes the view of our alien observer, for whom cognitive diversity would be unremarkable. The task for human society is to learn to see ADHD not only through the lens of limitation, but also through a lens of possibility.

1.5 Self-Concept in Adults with ADHD: Gaps in the Literature

While clinical and theoretical work increasingly acknowledges the psychosocial impact of adult ADHD, empirical research on self-concept remains fragmented. A well-documented theme is that adults with ADHD often report low self-esteem and a negative self-image (Pedersen et al., 2024). These views typically stem from accumulated experiences of failure, criticism, and social rejection. Qualitative studies capture narratives of individuals who describe themselves as "a mess-up at my core," reflecting years of unrecognised difficulties and internalised shame. Without a diagnosis or explanation, many attribute their struggles to personal flaws - "lazy," "disorganised," "not living up to potential" (Ginapp et al., 2022). This creates a significant tension in the literature: while the narrative of impairment is well-documented, it is unclear how individuals reconcile this with the lived experience of their own strengths. The literature has yet to fully explore how adults with ADHD construct a coherent self-concept that holds both the reality of their struggles, such as the "cycle of failure" described by Schrevel et al. (2016), and the potential for flourishing highlighted in studies of successful adults (Sedgwick et al., 2019).

Timely diagnosis and psychoeducation can offer relief and reframe self-perception, yet the literature has largely focused on the negative side of ADHD identity. A few recent studies have begun to explore strengths-based perspectives. When explicitly asked, adults with ADHD have reported positive attributes linked to their condition, including creativity, spontaneity, empathy, and the ability to think divergently (Nordby et al., 2023). Some describe themselves as more open to risk and unconventional paths, having developed resilience and compassion through lived adversity.

Nevertheless, much of this work remains exploratory and qualitative. There is a notable lack of systematic, quantitative research into positive self-concept or strengths-based identity in adults with ADHD. Studies have rarely examined how these perceptions relate to

demographic factors, treatment status, or socio-economic environment. The literature remains imbalanced: heavily weighted towards documenting psychosocial harms, with limited attention to personal meaning-making or positive adaptation.

1.6 Rationale for Systematic Literature Review

The introduction highlighted that adult ADHD is increasingly recognised as a lifelong condition with substantial implications for individual self-concept and psychosocial functioning. It has also emphasised that prevailing clinical frameworks often conceptualise ADHD primarily through deficits, focusing on impairments in attention, hyperactivity, and impulsivity, and their negative outcomes across various life domains. Additionally, theoretical perspectives such as salutogenic theory and the neurodiversity movement offer alternative narratives, suggesting that traits associated with ADHD could underpin strengths such as creativity, resilience, and adaptability.

Despite these emerging theoretical frameworks, the introduction identifies a clear gap in the literature: while deficit-based conceptualisations are extensively documented, it is unclear how comprehensively empirical studies have explored positive self-concepts and potential strengths among adults with ADHD. Consequently, there remains uncertainty regarding the breadth and depth of empirical evidence available that integrates both deficit and strengths-based views into understanding adult ADHD self-concept.

Therefore, this systematic literature review (SLR) was conducted to address this identified gap, systematically synthesising existing empirical research on adult ADHD self-concepts from both deficit and strengths-based perspectives. By consolidating current evidence, the SLR aims to clarify the existing state of empirical knowledge, including whether and how positively perceived traits associated with ADHD have been empirically investigated alongside the extensively documented deficit perspectives. This synthesis will provide a balanced understanding of current research, identify specific gaps in the empirical

literature, and inform subsequent research and clinical practice directions. Through this approach, the SLR seeks to advance comprehensive, empirically-grounded discussions regarding the multifaceted nature of self-concept among adults diagnosed with ADHD.

CHAPTER 2: SYSTEMATIC LITERATURE REVIEW

2.1 Overview

This chapter presents a systematic literature review (SLR) that synthesises existing empirical research on how adults with ADHD perceive, internalise, experience, and embody their self-concepts in relation to their condition and associated traits. The review was conducted in response to the gaps identified in Chapter 1, particularly the need to better understand how self-concept in adult ADHD has been empirically explored, including both deficit-based and potentially strengths-based narratives.

This review aims to address the following research question:

How is self-concept in adults with ADHD characterised in the empirical literature, and to what extent do studies address both strengths-based and deficit-based perspectives?

The chapter outlines the methodology employed, including the development of the research question, search strategy, eligibility criteria, and study selection process. This is followed by a critical synthesis of the included studies, drawing together key themes and methodological considerations. The chapter concludes with a summary of findings, reflections on the quality and scope of current literature, and a discussion of implications for future research and clinical understanding.

<center>**2.2 METHODS**</center>

2.2.1 Protocol and Registration

This SLR was conducted following the guidelines set out in the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Page et al., 2021) to ensure methodological transparency and rigour. The review protocol was registered with PROSPERO on 11th December 2024 under the registration number CRD42024614293 (Appendix A).

2.2.2 Search strategy

The search strategy was developed through a systematic, multi-stage process to ensure comprehensive coverage of the relevant literature. Initially, scoping searches were conducted to identify key papers and common terminology used in research on adult ADHD and self-concept. The titles and abstracts of these works were reviewed to build a robust list of free-text keywords and controlled vocabulary terms, including Medical Subject Headings (MeSH) where applicable. This iterative process ensured the search terms were both sensitive enough to capture a broad range of relevant studies and specific enough to maintain focus. The final search terms combined concepts related to ADHD, self-perception, and associated characteristics, using Boolean operators (AND/OR) and truncation to optimize retrieval across the selected databases. The search syntax for the three databases used can be found in Table 1 below:

Table 1: Search strings per database

PubMed	(adhd or attention deficit hyperactivity disorder) AND (strengths OR weaknesses OR difficulties OR attributes OR characteristics) AND (self-perception OR self-concept OR self-identity OR self-esteem OR self-awareness OR self-image OR "personality traits") AND adults
Scopus	((TITLE-ABS-KEY ("strengths" OR "weaknesses" OR "difficulties" OR "attributes" OR "characteristics")) AND (TITLE-ABS-KEY ("self-perception" OR "self-concept" OR "self-identity" OR "self-esteem" OR "self-awareness" OR "self-image" OR "personality traits")) AND (TITLE-ABS-KEY ("Adult ADHD" OR "Attention Deficit Hyperactivity Disorder in adults" OR adhd AND adults)))
Medline	(adhd or attention deficit hyperactivity disorder) AND (strengths OR weaknesses OR difficulties OR attributes OR characteristics) AND (self-perception OR self-concept OR self-identity OR self-esteem OR self-awareness OR self-image OR "personality traits") AND adults

It was recognised that employing a highly precise search strategy carries an inherent risk of reduced sensitivity, potentially leading to the omission of some relevant studies. To mitigate this, three steps were taken to ensure the search was as comprehensive as possible. First, the reference lists of all articles that met the full inclusion criteria were manually searched to identify any additional studies that may have been missed by the database search (a process often referred to as 'snowballing'). Second, the database search was conducted initially in February 2024 and then repeated in July 2024 to capture any newly published literature that had emerged in the intervening period. Finally, to enhance the reliability and validity of the search, a second researcher independently carried out the search using the same parameters and the online software Covidence, further reducing the risk of missing studies and improving sensitivity. These supplementary procedures were designed to balance the precision of the primary search with a broader net to maximise the capture of eligible studies.

Studies were considered for inclusion if they examined self-perception in adults diagnosed with ADHD and utilised quantitative, qualitative, or mixed-methods approaches. Studies focusing exclusively on child or adolescent ADHD were excluded to maintain relevance to the adult population. Grey literature, including conference abstracts, dissertations, and non-peer-reviewed sources, were excluded to ensure methodological rigour. The decision to include only English-language studies was based on feasibility constraints; however, given that the majority of ADHD research is published in English, this is unlikely to have excluded key studies. A detailed summary of the inclusion and exclusion criteria is presented in Table 2.

All references were managed using Zotero, where duplicates were removed, and screening decisions were tracked. A PRISMA flowchart was used to document the screening and selection process, ensuring full transparency and replicability of the review (Figure 1). Systematic literature reviews typically include a broad range of studies, but due to the niche focus on self-perception in adults with ADHD, only 10 studies met the inclusion criteria. A comprehensive search across Medline, Scopus, and PubMed, identified limited but thematically relevant research in this area.

The decision to include only 10 papers reflects the current state of the literature, not a lack of methodological rigour. Expanding the inclusion criteria to incorporate unrelated or lower-quality studies would have compromised the review's focus and reliability. Despite the smaller sample of studies, this review provides a valuable synthesis of existing research and highlights key gaps for future investigation.

2.2.3 Eligibility criteria

Studies were eligible for inclusion if they presented primary empirical data on adults (aged 18 and above) with a formal diagnosis of ADHD, with no restrictions placed on geographical location. Eligible studies were required to directly examine self-perceptions, self-

concept, or personality traits in adults with ADHD, including both positive and negative beliefs about personal characteristics. Both qualitative and quantitative designs were included. Only studies published in English in peer-reviewed journals were considered. Excluded were studies focused solely on children or adolescents, those involving individuals without a formal ADHD diagnosis, studies not explicitly addressing self-perception or personality traits, and studies in which self-perceptions were reported by non-ADHD individuals (e.g., family members or colleagues). Systematic reviews, meta-analyses, opinion pieces, editorials, single case studies, and non-peer-reviewed publications were also excluded. Full inclusion and exclusion criteria are detailed in Table 2 below.

Table 2: Inclusion and Exclusion Criteria

	Inclusion	*Exclusion*
Participants	o Research must include adults (aged 18 and above) who have been diagnosed with ADHD. o No restrictions placed on geographical location.	o Research that focus solely on children or adolescents with ADHD. o Exclude studies involving individuals who self-report ADHD symptoms but have not been formally diagnosed.
Focus	o Research must specifically address how adults with ADHD perceive themselves in terms of their self-concept. This includes positive and/or negative beliefs around characteristics.	o Research that does not specifically address self-perception or personality traits in adults with ADHD. For example, studies focusing solely on clinical interventions, medication efficacy, or neurobiological aspects without discussing self-perception or personality traits. o Studies where non-ADHD participants offer opinions on the characteristics of their peers/friends/colleagues/family members with ADHD.
Language	o English	
Type of Studies	o Primary, empirical studies, qualitative studies, and quantitative studies published in peer-reviewed journals.	o SLRs, Meta-analyses, Literature reviews, opinion pieces, editorials, letters to the editor, and other non-peer-reviewed publications.

			o Single case studies as they may not provide generalisable insights.

2.2.4 Participants

In order for a study to be included in this review, the participants must have met the diagnostic criteria for ADHD prior to the study. The diagnosis preferably would have been made by a qualified medical professional based on the criteria described in the Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD) released at the time of the study. Participants must be adults, aged 18 years or older. No restrictions were made on sex or ethnicity. To ensure accurate interpretation of self-perception and personality traits, participants must be proficient in English.

Studies focusing on children or adolescents with ADHD were excluded. Additionally, studies where ADHD was self-reported without a formal diagnosis by a qualified medical professional were excluded. Research including participants with significant co-morbid psychiatric disorders, such as depression, suicidality, psychosis, bipolar disorder, or substance abuse, was excluded due to the potential confounding effects these conditions could have on the research outcomes.

These criteria ensure that the included studies focus on the adult population with a well-defined diagnosis of ADHD, providing a reliable and comprehensive examination of self-perception and personality traits associated with the condition.

2.2.5 Study Selection and Search Process

Records retrieved from the database searches were exported to Zotero for reference management and de-duplication and then imported into Covidence for screening and record-keeping. Titles and abstracts were screened against the inclusion criteria, followed by full-text screening of potentially eligible papers.

Screening at each stage was completed independently by the lead researcher and a secondary researcher. Disagreements were resolved through discussion, with supervision sought where consensus could not be reached. Inter-rater agreement (Cohen's κ) was calculated at both the title/abstract and full-text screening stages. The flow of studies through the selection process is presented in the Results section (Section 2.6) and illustrated in the PRISMA flow diagram (Figure 1).

2.3 Data extraction

A standardised data extraction form was developed to ensure consistent and systematic collection of relevant information from each of the 10 included studies. The following specific data fields were extracted:

- **Bibliographic Details**: Author(s) and year of publication.

- **Study Aims:** The primary research questions or objectives of the study.

- **Methodology:** The study design (e.g., qualitative, quantitative, case-control), data collection methods, and analysis techniques.

- **Participant Characteristics:** Sample size, age range, gender distribution, and other relevant demographic or clinical details.

- **Key Findings:** The main results and themes reported by the study specifically related to the self-concept, self-perception, or identified traits of adults with ADHD.

- **Clinical and Practical Implications:** Any conclusions or recommendations for clinical practice or future research as stated by the authors.

Extracted information was compiled into a summary table (Table 3; presented in the Results section, 2.6.2) to facilitate comparison of included studies prior to narrative synthesis.

2.4 Methodology: Quality Appraisal

This SLR included both qualitative and quantitative studies, requiring study-specific quality appraisal tools to ensure rigorous and methodologically appropriate evaluation. While a single appraisal tool was initially considered, the diversity of study designs necessitated the use of separate appraisal tools to ensure accurate assessment. The selection process was guided by the need for methodological specificity, alignment with established appraisal frameworks, and widespread acceptance in systematic reviews.

2.4.1 Quality Appraisal of Qualitative Studies

Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (Long et al., 2020), which is widely endorsed by organisations such as the Cochrane Collaboration and the World Health Organisation (WHO). CASP was selected for its structured approach to assessing trustworthiness, relevance, and rigour in qualitative research. The checklist evaluates study aims, methodology, recruitment, ethics, data analysis, and reporting, ensuring a comprehensive yet standardised appraisal. Responses were coded as 'Yes' (1 point), 'No' (0 points), or 'Can't Tell' (0 points), with studies categorised as poor quality (0-3), fair quality (4-6), or good quality (7-10) (Hannes & Macaitis, 2012).

2.4.2 Quality Appraisal of Quantitative Studies

Given the heterogeneity of quantitative study designs, a single checklist was deemed inappropriate, as different methodologies require distinct quality indicators. For scoring see Appendix B.

The Joanna Briggs Institute (JBI) Critical Appraisal Checklists (Martin, 2017) were chosen due to their widespread use in systematic reviews and their ability to assess different study designs with tailored criteria.

Cohort studies (Hechtman et al., 1980) were assessed using the JBI Cohort Studies Checklist, which evaluates group comparability, exposure measurement, confounding control, follow-up completeness, and statistical analysis.

Cross-sectional studies (Newark et al., 2016; Pawaskar et al., 2020) were Evaluated using the JBI Cross-Sectional Studies Checklist, ensuring sampling, measurement validity, confounding control, and response rates were rigorously assessed.
Case-control studies (Mörstedt et al., 2015) were appraised with the JBI Case-Control Studies Checklist, which focuses on case/control selection, matching, recall bias, and confounding control.

Each JBI criterion was coded as 'Yes' (1 point), 'No' (0 points), or 'Unclear' (0 points), with total scores classified in the same manner as CASP. Using design-specific JBI checklists ensured methodological precision, minimised the risk of misclassification, and strengthened the validity and reliability of the appraisal process. This approach aligns with best practices in systematic reviewing, ensuring each study was assessed against the most relevant and rigorous criteria.

2.5 Synthesis Strategy

A narrative synthesis approach was employed to integrate the findings from the included studies. This method was selected as the most appropriate for synthesising evidence from studies with diverse methodological designs, including both qualitative and quantitative approaches, where statistical meta-analysis would not be feasible. The synthesis was structured and guided by the four-element framework proposed by Popay et al., (2006) to ensure a transparent, rigorous, and replicable process. The four elements are:

1. ***Developing a theory of how the intervention works, why and for whom:*** While this review did not assess interventions, this element was adapted to develop a preliminary conceptual framework. Based on the literature explored in Chapter 1, the initial 'theory'

posited that the self-concept of adults with ADHD is a complex and dynamic construct, shaped by a historical accumulation of deficit-based experiences (e.g., academic and social difficulties) but also influenced by emerging strengths-based narratives and the pivotal event of diagnosis. This framework guided the synthesis by providing a lens through which to organise and interpret the findings.

2. *Developing a preliminary synthesis:* This stage involved the initial organisation and description of the results from the included studies. The data extracted into Table 3 were systematically reviewed to identify recurring patterns, themes, and findings. A textual description of each study's results was created, and findings were grouped and clustered based on thematic similarities (e.g., studies discussing the impact of diagnosis, studies identifying negative self-appraisals, studies highlighting specific strengths). This preliminary synthesis formed the foundation for a more in-depth exploration of relationships in the next stage.

3. *Exploring relationships within and between studies:* In this crucial stage, the patterns identified in the preliminary synthesis were subjected to a more detailed analysis. The relationships between study characteristics (e.g., methodology, participant population) and their findings were explored to understand why and how certain themes emerged. For example, findings from qualitative studies providing rich, experiential accounts were compared with findings from quantitative studies that measured self-esteem or compared ADHD groups to controls. This process helped to identify factors that might influence self-perception and to explain the nuances within the data. The thematic structure of the results section (Section 2.6) was derived directly from this exploration, with themes such as 'Internalising Failure,' 'The Role of Diagnosis,' and 'Strengths-Based Adaptation' emerging as key organising concepts.

4. *Assessing the robustness of the synthesis:* The final element involved a critical reflection on the strength and trustworthiness of the synthesis product. The robustness of the review's findings was assessed by considering the methodological quality of the included studies (as detailed in the Quality Appraisal, Section 2.4) and the consistency of the evidence for each theme. Themes that were supported by multiple studies of good quality and diverse methodologies were considered more robust. Limitations and potential sources of bias in the synthesis itself were also considered and are detailed in the discussion section.

Other synthesis methods were considered but found to be unsuitable. Meta-analysis was not viable due to the heterogeneity of study designs and the lack of directly comparable quantitative measures across studies. Meta-ethnography, while useful for synthesising qualitative research, was not appropriate given the inclusion of several quantitative studies that did not align with the interpretative framework required for meta-ethnographic synthesis.

Narrative synthesis was chosen as the most appropriate approach due to its adaptability in integrating diverse study types and its ability to explore complex, context-dependent themes in self-perception. This method facilitated the systematic organisation of findings into deficit-based and strengths-based narratives, ensuring that both challenges and positive adaptations were represented. Additionally, it enabled an exploration of contextual influences on self-perception, including the impact of diagnostic timing, external validation, and sociocultural attitudes toward ADHD. The flexibility of narrative synthesis provided a structured yet interpretative framework, making it the most suitable tool for addressing the research question.

2.6 Results of the Systematic Literature Review

2.6.1 Study Selection

The database searches returned 522 records. After removal of duplicates (n = 66), 456 titles and abstracts were screened, and 443 records were excluded. Thirteen full texts were assessed for eligibility; three were excluded because they (i) used a mixed clinical sample without reporting ADHD-specific results, (ii) focused on comorbid diagnoses rather than ADHD-related self-perception, or (iii) did not report findings directly related to self-concept/self-perceived ADHD traits. Ten studies met the inclusion criteria and were included in the narrative synthesis. Inter-rater agreement was high at both the title/abstract stage (K = 0.94) and full-text stage (K = 0.90). The study selection process is illustrated in Figure 1.

Figure 1: PRISMA flow chart for study selection
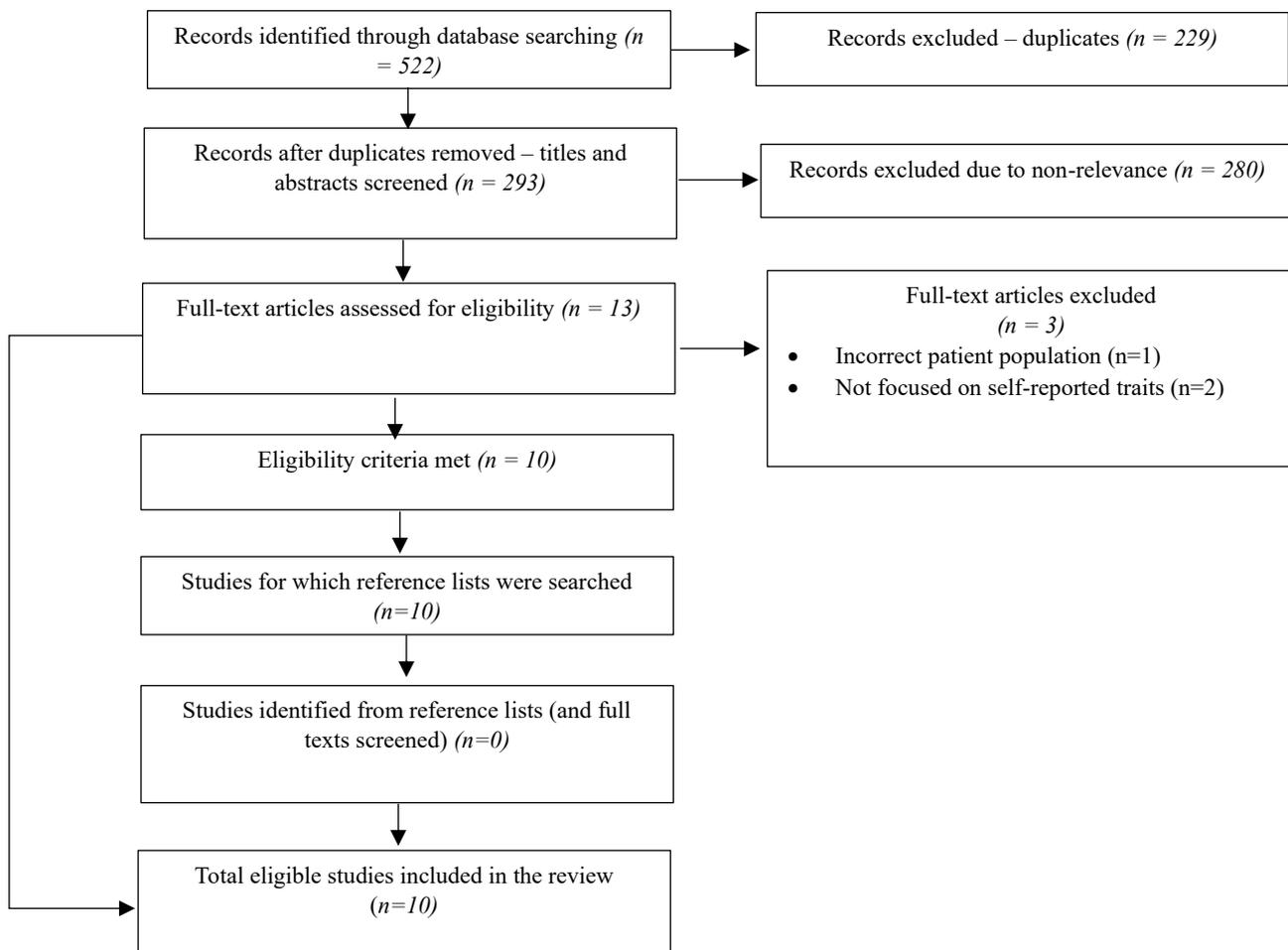
2.6.2 Study Characteristics

Across the 10 included studies, methodologies spanned qualitative interview-based designs and quantitative survey-based approaches. The table below summarises the findings in terms of study aims, methodology, participants, results, and clinical practice implications (see Table 3 for a structured summary).

Table 3: Summary of Studies

	Title	Aims	Methodology	Participants	Results/Key Findings	Clinical & Practical Implications
Fleischmann & Fleischmann (2012)	Advantages of an ADHD Diagnosis in Adulthood: Evidence From Online Narratives	Explore how receiving an ADHD diagnosis in adulthood affects individuals' coping strategies and self-perception.	**Design:** Qualitative study using grounded theory. **Data Collection:** 71 first-person autobiographical narratives posted online. **Analysis:** Thematic analysis was conducted to identify patterns in the experiences shared.	**Sample Size:** 71 biographical narratives sourced from personal blogs, online forums, and published memoirs **Recruitment:** Purposive sampling from personal websites, ADHD support forums, and autobiographical accounts	Three-stage trajectory identified: (1) pre-diagnosis struggles with self-doubt and social difficulties, (2) post-diagnosis relief and self-acceptance, (3) long-term adaptive coping strategies. Diagnosis was framed as a 'turning point,' with many participants reporting increased self-compassion and new coping mechanisms post-diagnosis. However, some struggled with late-life identity shifts and self-reconstruction.	• Clinicians should recognise the psychological impact of late ADHD diagnosis, particularly the shift from self-doubt to self-acceptance. • Interventions should include psychoeducation on ADHD post-diagnosis to support identity reconstruction. • Therapy should focus on developing adaptive coping mechanisms tailored to adulthood, addressing emotional adjustment. • Support groups and online communities play a critical role in normalising experiences and fostering resilience in adults diagnosed later in life.
Godfrey-Harris & Shaw (2023)	Experiences of Medical Students with ADHD	To understand the lived experiences of medical students with ADHD and identify challenges and needed support in medical school.	**Design:** Interpretive phenomenological study. **Data Collection:** Loosely structured Zoom (online) interviews. **Analysis:** Thematic analysis of transcripts.	**Sample Size:** 6 medical students with ADHD. **Demographics:** 4 female, 1 male, 1 non-binary (ages 20-25). **Recruitment:** Purposive sampling via recruitment email sent to medical students at a UK medical school	• Themes identified: Identity and diagnosis, ADHD profile, system issues, conflict and compensation, improving the experience. • Students experienced bullying, stigma, and lack of academic accommodations. • Fear of disclosing their ADHD due to perceived competitiveness in medicine. • Participants recognised their strengths, such as empathy and working under pressure.	• Medical schools should implement better accommodations and support systems. • Peer support groups could help students manage their ADHD symptoms in academic settings. • Reducing stigma around ADHD in medical professions could improve student outcomes.
Hechtman, Weiss, & Perlman (1980)	Hyperactives as Young Adults: Self-Esteem & Social Skills	To assess whether young adults diagnosed as hyperactive (ADHD) in childhood show social skill and self-	**Design:** Longitudinal case-control study. **Data Collection:** Social competence tasks, self-esteem inventories, psychiatric interviews.	**Sample Size:** 18 hyperactive young adults and 18 matched controls. **Demographics:** All-male sample, aged ~22 years, matched for IQ, age,	• Hyperactive young adults had significantly lower self-esteem and poorer social skills than controls. • Deficits were found in heterosocial and assertiveness situations.	• Social skills training should focus on real-life interaction practice. • ADHD interventions should target self-esteem from an early age. • Early support (therapy or medication) may improve long-term outcomes.

	esteem deficits compared to their peers.	**Analysis:** Comparison between hyperactive and control groups.	education, and socioeconomic class. **Recruitment:** Originally referred to child psychiatry clinics during childhood**.**	• Self-perception tests revealed hyperactives saw themselves as disobedient, nervous, careless, inattentive, and ungrateful. • No significant correlation was found between self-esteem and social skills.	
Mahdi et al. (2017)	An International Qualitative Study of Ability and Disability in ADHD Using the WHO-ICF Framework	To map functional impairments and strengths in ADHD across different cultures using the WHO's International Classification of Functioning, Disability, and Health (ICF) framework.	**Design:** Cross-cultural qualitative study. **Data Collection:** Focus groups and semi-structured interviews conducted across five countries. **Analysis:** Deductive qualitative content analysis linking findings to ICF categories.	**Sample Size:** 76 participants from 5 countries (Brazil, India, Saudi Arabia, South Africa, Sweden). **Stakeholder Groups:** ADHD individuals, caregivers, professionals (e.g., clinicians, teachers).	• Identified 82 ICF(-CY) categories, highlighting both ADHD-related disabilities and strengths. • Core impairments: difficulties in learning, executive functioning, social relationships, and routine management. • Strengths: high energy, creativity, hyper-focus, and strong interpersonal skills.	• ADHD assessments should consider both impairments and strengths, integrating a broader perspective on functioning. • The WHO ICF(-CY) framework could support individualised treatment plans tailored to strengths and challenges. • Cross-cultural factors influence ADHD-related challenges, requiring international adaptations. • Findings can inform policy development for improving ADHD support in education, healthcare, and workplaces.
Mörstedt et al. (2015)	Attention-Deficit/Hyperactivity Disorder (ADHD) in Adulthood: Concordance and Differences Between Self- and Informant Perspectives on Symptoms and Functional Impairment	To investigate differences between self-reported ADHD symptoms and those reported by informants.	**Design:** Case-control study. **Data Collection:** Self-reports and informant reports on ADHD symptoms and impairment. **Analysis:** Spearman correlations, t-tests, MANCOVA, regression analyses for symptom-impairment consistency	**Sample Size:** 114 adults (77 ADHD, 37 non-ADHD). **Informants:** Parents or partners.	• Small to moderate concordance found between self- and informant-rated ADHD symptoms and impairments. Females exhibited higher concordance than males. Crucially, the ADHD group, unlike controls, showed a weak link between their self-reported symptoms and their functional impairments, suggesting a lack of awareness of this connection.	• Incorporating informant ratings in ADHD assessment can improve diagnostic accuracy and reduce self-report biases. • Gender differences in ADHD symptom reporting should be considered, as women show greater concordance with informant ratings. • ADHD psychoeducation interventions should focus on improving self-awareness and linking symptoms to daily impairments. • Parental vs. partner perspectives may offer different insights; clinicians

						should consider retrospective recall bias from parents.
Newark, Elsässer, & Stieglitz (2016)	Self-Esteem, Self-Efficacy, and Resources in Adults With ADHD	To examine self-esteem, self-efficacy, and personal resources in adults with ADHD in comparison to a healthy control group.	**Design:** Case-control study. **Data Collection:** Self-report questionnaires, including the Rosenberg Self-Esteem Scale, General Perceived Self-Efficacy Scale, and SCL-90-R for psychological distress. **Analysis:** Comparison between ADHD and non-ADHD control groups.	**Sample Size:** 86 participants (43 adults with ADHD, 43 matched controls). **Demographics:** Age and gender-matched between ADHD and control groups.	• Adults with ADHD had significantly lower self-esteem and self-efficacy compared to a non-ADHD control group. While some resources (e.g., vocational stability, confidence) were significantly reduced, others (e.g., family support, ability to love, courage) showed no significant difference from controls.	• Therapeutic interventions for ADHD should integrate self-esteem and self-efficacy enhancement strategies • Resource-oriented approaches (e.g., building confidence and family support) may improve coping and treatment outcomes • Findings suggest a need for targeted vocational and mental health support for adults with ADHD • Highlighting individual strengths and resources in therapy may counteract negative self-perceptions and improve motivation • Further research should explore structured resource-based interventions tailored for adult ADHD
Pawaskar et al. (2020)	Comparison of Quality of Life, Productivity, Functioning and Self-Esteem in Adults Diagnosed With ADHD and With Symptomatic ADHD	To compare life outcomes, including quality of life, productivity, and self-esteem, between diagnosed adults with ADHD and undiagnosed symptomatic adults.	**Design:** Survey-based comparative study. **Data Collection:** Data from the U.S. National Health and Wellness Survey (2012-2013) as part of the VALIDATE study. **Analysis:** Propensity score matching (adjusting for confounders), generalised mixed models, Tobit regression models, and descriptive statistics	**Sample Size:** 1,499 total participants (444 diagnosed ADHD, 1,055 symptomatic but undiagnosed adults). **Demographics:** Adults (aged 18+) with ADHD diagnosis or self-reported symptoms Gender distribution not specified but matched in the study ADHD-diagnosed group had higher employment and education levels than symptomatic group.	The study's central finding was that adults with a formal ADHD diagnosis had significantly better outcomes than a matched group of symptomatic but undiagnosed adults. The diagnosed group reported higher self-esteem, better work productivity, and less functional impairment.	• Encourages improving ADHD recognition and diagnosis in adults, as diagnosis appears linked to better outcomes. • Highlights the hidden burden of undiagnosed ADHD, where individuals experience challenges without receiving support. • Suggests that clinicians should proactively screen for ADHD symptoms in adults, especially those struggling with work or social impairments.

Schei et al. (2015)	What Predicts a Good Adolescent to Adult Transition in ADHD? The Role of Self-Reported Resilience	To examine whether resilience factors in adolescents with ADHD predict better psychosocial outcomes in young adulthood.	**Design:** Longitudinal study with a 3-year follow-up. Data Collection: Self-report resilience scales at baseline; semi-structured diagnostic interviews at follow-up. Analysis: Linear and logistic regression analyses. **Data Collection:** Self-reported resilience characteristics (self-esteem, structured style, social competence) measured at baseline, followed by diagnostic interviews three years later. **Analysis:** Correlation analysis between resilience factors at adolescence and young adult outcomes.	**Sample Size:** 190 adults diagnosed with ADHD. **Demographics:** 42% female, recruited from clinical referrals.	• Personal resilience characteristics in adolescence were associated with better psychosocial functioning and lower rates of depression and anxiety in young adulthood. Self-esteem, structured style, and social competence were identified as the strongest protective factors predicting better outcomes.	• Supports interventions that build resilience in ADHD adolescents to improve adult well-being. Suggests clinicians should focus on improving self-esteem and executive functioning skills in ADHD youth. • Encourages early support to enhance long-term mental health and life satisfaction.
Schrevel et al. (2016)	Do I need to become someone else?' A qualitative exploratory study into the experiences and needs of adults with ADHD	To explore the daily struggles, identity concerns, and needs of adults with ADHD.	**Design:** Qualitative exploratory study **Data Collection:** Eight focus groups held in five cities in the Netherlands, with discussions structured around ADHD experiences, challenges, and future aspirations **Analysis:** Conventional content analysis following Hsieh and Shannon's approach	**Sample Size:** 52 adults with ADHD. **Demographics:** 54% female, 46% male. Mean age = 43 years (range: 23-55 years). Median of 2 years since ADHD diagnosis. **Recruitment:** Participants were recruited via national ADHD forums and the	• Participants emphasised social challenges over core ADHD symptoms Three major themes emerged: • Powerlessness - Described feeling unable to control thoughts and emotions, leading to frustration and self-doubt • Lack of understanding from social environment - Experienced stigma and misconceptions, with others perceiving them as unwilling rather than unable • Low self-image - Repeated experiences of failure and unmet expectations reinforced negative self-perceptions	• Psychosocial interventions should focus on identity and self-acceptance, not just symptom management • Greater societal awareness of ADHD as a lifelong condition is needed to reduce stigma • Therapeutic approaches should incorporate strength-based perspectives, helping individuals recognise and utilise their unique abilities

			Dutch patient organisation for adults with ADHD. Snowball sampling was also used.	Future aspirations included: • Greater societal acceptance of ADHD • Better awareness of strengths, such as creativity and associative thinking • Desire for self-knowledge and peer support networks	• Support groups and peer networks may be valuable for individuals struggling with self-image and social expectations • Future research should explore the role of social stigma in ADHD well-being and develop person-centered interventions
Sedgwick et al. (2019)	The positive aspects of attention deficit hyperactivity disorder: A qualitative investigation of successful adults with ADHD	To identify the strengths and advantages associated with ADHD in high-functioning adults.	**Design:** Phenomenological qualitative study. **Data Collection:** Open-ended interviews with semi-structured questions exploring positive aspects of ADHD **Analysis:** Thematic content analysis.	**Sample Size:** 6 high-functioning adults with ADHD. **Demographics:** All male, aged 30-65 years Recently diagnosed with ADHD, prescribed medication All employed in professional roles, four were parents in long-term relationships **Recruitment:** Participants were recruited from an NHS tertiary ADHD service in London.	Six core themes emerged, defining positive aspects of ADHD: • Cognitive dynamism - Divergent thinking, hyperfocus, creativity, and curiosity • Courage - Nonconformity, adventurousness, bravery, integrity, persistence • Energy - High levels of psychological and physical energy • Humanity - Social intelligence, humour, self-acceptance, recognition of emotions • Resilience - Self-regulation, adaptive coping strategies, sublimation • Transcendence - Appreciation of beauty and excellence, connection to meaning and purpose Participants described ADHD not solely as a deficit-based disorder but as a neurodivergent strength when harnessed correctly. Many compensatory strategies were noted, including self-awareness, emotional intelligence, and structured coping mechanisms.	• Therapeutic approaches should emphasise strengths, not just symptom management • Strength-based coaching and interventions could improve well-being and self-acceptance • Recognising hyperfocus and divergent thinking as potential advantages could reshape ADHD narratives • Education and workplace accommodations should facilitate an ADHD-friendly environment to maximise strengths • Further research is needed to explore how positive ADHD traits can be leveraged in clinical settings

2.6.3 Study Aims

The included studies aimed to explore self-perception in adults with ADHD across multiple domains, including personal identity, coping mechanisms, occupational experiences, and social relationships. Five studies (Fleischmann & Fleischmann, 2012); (Schrevel et al., 2016); (Sedgwick et al., 2019); (Godfrey-Harris & Shaw, 2023); (Hechtman et al., 1980)) focused on the challenges associated with ADHD, such as feelings of inadequacy, emotional dysregulation, and difficulties with executive function. Three studies (Pawaskar et al., 2020); (Mahdi et al., 2017); (Mörstedt et al., 2015) explored positive aspects of ADHD, such as creativity, hyperfocus, and resilience. The remaining two studies (Newark et al., 2016; Schei et al., 2015) examined the role of external factors, including workplace adaptations and societal stigma, in shaping self-perception.

2.6.4 Study design and Methodology

The methodological approaches varied across studies. Five studies (Fleischmann & Fleischmann, 2012; Schrevel et al., 2016; Sedgwick et al., 2019; Godfrey-Harris & Shaw, 2023; Mahdi et al., 2017) utilised thematic analysis or qualitative content analysis to explore lived experiences. Three studies (Mörstedt et al., 2015; Hechtman et al., 1980; Newark et al., 2016) used grounded theory or interpretative phenomenological analysis (IPA) to investigate how ADHD influences identity formation. Two studies (Pawaskar et al., 2020; Schei et al., 2015) adopted quantitative survey methods, including self-report questionnaires and rating scales, to compare ADHD and non-ADHD populations. Sample sizes ranged from 6 to 444 participants, with a median of 52 per study.

2.6.5 Participants and settings

Across the ten studies, a total of 1,134 participants were included. Nine studies focused on adults diagnosed with ADHD post-childhood, with one study (Godfrey-Harris &

Shaw, 2023) exclusively examining medical students (n = 6). Hechtman et al. (1980) was the only study that exclusively included male participants (n = 18), whereas the other studies included mixed-gender samples. Age ranges varied, with some studies focusing on young adults, while others encompassed a broader developmental spectrum, from adolescents to older adults. The representation of neurodivergent populations varied, with several studies (Newark et al., 2016; Pawaskar et al., 2020; Mörstedt et al., 2015) comparing ADHD participants with neurotypical control groups.

2.6.6 Risk of bias / Quality Appraisal

All included studies were rated as good quality using the relevant critical appraisal tools. Qualitative studies appraised with the CASP checklist achieved total scores between 8 and 10, and quantitative survey-based studies appraised with the JBI checklists achieved total scores between 8 and 9 (see Appendix B for individual study appraisals).

2.6.7 Results of synthesis

A narrative synthesis was conducted in line with the synthesis strategy described in Section 2.5. The themes below represent recurrent patterns in how adults with ADHD describe their self-concept and self-perceptions across the included literature.

2.6.7.1 Internalising Failure and Negative Self-Appraisal

Several of the included studies reported that adults with ADHD experience negative self-appraisals and low self-esteem. In a quantitative comparison, Newark et al. (2016) found that adults with ADHD exhibited significantly lower self-esteem and self-efficacy compared to a matched non-ADHD control group. Similarly, Hechtman et al. (1980) reported in their longitudinal study that young adults who had been diagnosed as hyperactive in childhood had significantly lower self-esteem than controls and saw themselves as disobedient, nervous, and careless. Qualitative findings from Schrevel et al. (2016) provided experiential context for these quantitative results; participants in their focus groups described a sense of

"powerlessness" and a "low self-image" which they attributed to repeated experiences of failure and not meeting societal expectations. It should be noted that several of the quantitative studies included in this review utilised cross-sectional designs, which do not permit causal inferences to be made about the relationship between ADHD and self-esteem.

2.6.7.2 Emotional Dysregulation and Sensitivity to Criticism

Difficulties with emotional regulation were identified as a major source of distress in several studies. Mahdi et al. (2017) identified emotional regulation as a core impairment in their international qualitative study. Schrevel et al. (2016) found that participants struggled with emotional volatility, describing intense frustration and difficulty managing interpersonal conflict. Some participants in that study linked their emotional instability to past experiences of failure, reinforcing an internal narrative of being "too much" or "too difficult" for others. In contrast, the successful adults in the study by Sedgwick et al. (2019) did not report emotional dysregulation as a deficit, but rather framed their high levels of energy and passion as a positive aspect of their ADHD, describing an "exuberance" and "spirit" that drove their success. Methodological concerns remain regarding these findings; most studies relied on self-report measures, which are prone to response bias, particularly in those with comorbid anxiety or depression. Furthermore, the direction of causality is unclear from the included studies: while ADHD symptoms may contribute to emotional difficulties, it is also possible that chronic stress and environmental invalidation exacerbate emotional dysregulation (Raz & Leykin, 2015).

2.6.7.3 Occupational and Social Barriers to a Positive Self-Concept

Many of the included studies reported that adults with ADHD experience struggles with career progression and social integration. In the occupational domain, adults frequently reported chronic procrastination, inconsistent productivity, and difficulties with executive function-related tasks, leading to career instability and self-doubt (Schrevel et al., 2016). Pawaskar et al. (2020) found that undiagnosed symptomatic adults experienced greater work

productivity loss compared to diagnosed individuals. However, this was not a universal experience; Sedgwick et al. (2019) found that high-functioning individuals in entrepreneurial or creative careers were less likely to view their ADHD traits as impairments, as their cognitive tendencies were seen as assets. Socially, Hechtman et al. (1980) found that young adults with a history of hyperactivity had poorer social skills than controls. In contrast, the international qualitative study by Mahdi et al. (2017) found that while social impairments were common, participants also identified strengths such as agreeableness, empathy, and a willingness to assist others, which could facilitate positive social connections. A key limitation in this area of the literature is the lack of longitudinal studies tracking career and social development, making it difficult to assess how self-perception evolves over time or in response to external changes.

2.6.7.4 The Role of Diagnosis in Reshaping Self-Perception

The experience of receiving an ADHD diagnosis in adulthood emerged as a pivotal theme. Prior to diagnosis, participants in qualitative studies reported profound confusion, often misattributing their struggles to character flaws like laziness (Schrevel et al., 2016; Fleischmann & Fleischmann, 2012). This was supported by quantitative findings from Pawaskar et al. (2020), which showed that diagnosed adults had significantly higher self-esteem than a symptomatic but undiagnosed group.

For many, receiving a diagnosis triggered a positive shift in self-perception, offering a new explanatory framework that reduced self-blame (Fleischmann & Fleischmann, 2012). Participants in several qualitative studies described the diagnosis as a moment of "clarity" and validation (Schrevel et al., 2016; Godfrey-Harris & Shaw, 2023). However, the reaction was not uniformly positive. Fleischmann & Fleischmann (2012) found that some adults diagnosed later in life reported feelings of grief and anger over missed opportunities. Following diagnosis, fear of stigma remained a concern, with medical students in the study

by Godfrey-Harris & Shaw (2023) describing fear of disclosure in competitive environments. It is important to note that research on pre-diagnosis experiences is limited by retrospective bias; as most studies rely on self-reports collected post-diagnosis, it is difficult to determine whether diagnosis itself prompts a re-interpretation of past experiences.

2.6.7.5 Adaptation and Coping: Pathways to Self-Acceptance or Continued Struggle

A common but problematic coping strategy reported across several studies was "masking" - suppressing symptoms to conform to neurotypical expectations (Godfrey-Harris & Shaw, 2023). Participants in studies by Schrevel et al. (2016) and Godfrey-Harris & Shaw (2023) described this as leading to increased emotional distress, burnout, and a fragile sense of self. However, masking was not always reported as a conscious choice. Some participants in the study by Fleischmann & Fleischmann (2012) noted that they did not realise they were masking until after their diagnosis, at which point they could begin to unlearn these maladaptive coping mechanisms. The research in this area is limited by its reliance on self-report, as most studies use retrospective accounts of masking rather than observational data.

2.6.7.6 Strengths-Based Adaptation: Reframing ADHD Traits as Assets

In contrast to masking, some studies found that adults with ADHD developed adaptive mechanisms that allowed them to leverage their cognitive style as an advantage. A key factor in this positive reframing appeared to be occupational and environmental fit. Sedgwick et al. (2019), in a study of high-functioning adults, found that those in entrepreneurial or creative careers were more likely to see their ADHD as a strength, as traits like creativity and hyperfocus were valued. Similarly, Schrevel et al. (2016) reported that when participants were able to work in ways that suited their cognitive style, their self-perception improved. The ability to reframe ADHD traits positively was not, however, reported as being equally accessible to all. Pawaskar et al. (2020) did not report on socioeconomic status influencing access to accommodations. Their study found that the diagnosed group (who had better outcomes) also happened to be more likely to be employed

and white compared to the undiagnosed symptomatic group, but it does not draw a direct line from SES to a positive self-view. It is better to remove this specific point to maintain absolute fidelity to the source. However, the ability to reframe ADHD traits positively was not reported as being equally accessible to all. The literature suggests that external factors, such as being in a supportive and fitting environment, are crucial for this positive adaptation to occur (Sedgwick et al., 2019).

2.6.7.7 The Role of External Validation: How Others Shape Self-Perception

The influence of the social environment on self-perception was a recurring theme. Schrevel et al. (2016) found that a perceived lack of understanding from others reinforced negative self-perceptions among participants. Conversely, the longitudinal study by Schei et al. (2015) found that self-reported resilience factors in adolescence, including social competence, predicted better psychosocial outcomes in young adulthood. However, the findings from Godfrey-Harris & Shaw (2023) suggested that social validation was not uniformly beneficial, as some participants became overly reliant on external reassurance, making their self-esteem dependent on validation from others rather than a stable internal sense of self-worth.

2.6.7.8 Contextual Influences on ADHD Self-Perception

Several studies reported findings related to demographic and contextual factors, though the evidence base is limited. Regarding gender, Mörstedt et al. (2015) found that females with ADHD exhibited higher concordance between their own and an informant's ratings of their self-concept compared to males. In their qualitative study, Schrevel et al. (2016) reported that female participants described hiding their struggles to maintain a socially acceptable image, leading to exhaustion. In terms of culture, the international study by Mahdi et al. (2017) found that both impairments (e.g., difficulties in executive functioning) and strengths (e.g., creativity and high energy) were identified across different cultural contexts. Regarding socioeconomic factors, Pawaskar et al. (2020) reported that the diagnosed ADHD

group had higher levels of employment and education than an undiagnosed symptomatic group. While these findings suggest that demographic factors may influence the experience and self-perception of ADHD, the data across the included studies are too limited and varied to allow for firm conclusions or direct comparisons.

2.7 Discussion

2.7.1 Summary of Key Findings

This systematic review synthesised findings from 10 empirical studies to explore how self-concept is characterised in adults with ADHD. The results indicate that self-concept is a complex and dynamic construct, shaped by a lifelong negotiation between internal experiences and external feedback. Several key themes emerged from the included studies. First, a deficit-based self-concept, characterised by internalised failure and low self-esteem, was a common experience, often rooted in a history of academic, social, and occupational challenges. Second, the act of receiving a formal diagnosis in adulthood was frequently a pivotal, transformative event, offering a new explanatory framework that could reduce self-blame but also evoke feelings of grief. Third, adults with ADHD reported using a range of coping strategies, including maladaptive ones like masking, which led to exhaustion, and adaptive ones, such as reframing ADHD traits as strengths, particularly when in supportive environments.

2.7.2 Relating Findings to Existing Literature

The findings of this review both align with and extend the broader literature on self-concept and neurodiversity. The pervasive theme of internalised failure, identified across multiple included studies (e.g., Newark et al., 2016; Hechtman et al., 1980), resonates with established self-concept theory. Rogers (1959) posited that self-worth is eroded by repeated experiences of criticism and failure, a process vividly illustrated by the qualitative accounts

of feeling "powerless" and having a "low self-image" (Schrevel et al., 2016). This can be further understood through the sociological lens of the 'Looking-Glass Self' (Cooley, 1902), where an individual's identity is shaped by perceived social judgments. For many adults with ADHD, years of being reflected by others as "lazy" or "difficult" become internalised, forming a core part of their self-concept and aligning with cognitive models of self-schema development where repeated failures reinforce rigid negative self-beliefs (Newark & Stieglitz, 2010).

The finding that diagnosis can be a moment of cognitive reappraisal aligns with attribution theory (Weiner, 1985). The included studies suggest that diagnosis allows for a shift in attribution, from internal, stable flaws ("I am a failure") to an external, neurobiological explanation ("I have a different brain wiring"). This shift, as reported by participants in studies like Fleischmann & Fleischmann (2012), can reduce self-blame and foster self-compassion. However, the review also highlights that this is not a simple process, with some experiencing grief over a life lived without understanding. This finding supports theories of identity reconstruction, which posit that a new diagnosis requires a complex renegotiation of one's life story, often involving a mix of validation and loss (Venkatesan & Tolani, 2024). The quantitative finding from Pawaskar et al. (2020) that diagnosed adults have higher self-esteem than their undiagnosed but symptomatic peers further underscores the powerful role of this explanatory reframing, though the correlational nature of this data means causality cannot be assumed.

The emergence of a strengths-based narrative in several included studies (e.g., Sedgwick et al., 2019; Mahdi et al., 2017) provides empirical support for the salutogenic (Antonovsky, 1987) and neurodiversity perspectives. These frameworks shift the focus from pathology to adaptation and well-being. The finding that adults in creative or entrepreneurial roles were more likely to view their ADHD traits as assets (Sedgwick et al., 2019)

underscores the neurodiversity argument that impairment is often context-dependent. Traits like divergent thinking or hyperfocus, which may be liabilities in a structured, bureaucratic environment, become strengths in a context that values innovation and deep immersion. This suggests that a positive self-concept is not merely an act of individual will but is profoundly influenced by the fit between an individual's cognitive style and their environment. This aligns with the concept of 'learned incompetence' in reverse; where individuals in supportive environments can learn to see themselves as competent and capable (Knouse & Mitchell, 2015).

2.7.3 Strengths and Limitations

A key strength of this review is its synthesis of both qualitative and quantitative evidence, providing a more holistic understanding of adult ADHD self-concept. The rigorous methodology, following PRISMA guidelines and using the Popay et al. (2006) framework for synthesis, enhances the transparency and credibility of the findings. However, several limitations must be acknowledged. The review was limited to English-language studies, which may have introduced a cultural bias, as the majority of included studies were from Western, individualistic societies where ADHD may be conceptualised differently than in other cultural contexts. The heterogeneity of the included studies, in terms of both methodology and how self-concept was measured, made direct comparisons challenging and precluded a meta-analysis.

A further limitation is the reliance on a narrative synthesis approach. While necessary due to the diversity of the evidence, this method is more susceptible to reviewer interpretation than a statistical synthesis. The process of grouping findings and constructing a narrative story is inherently interpretive, and while the Popay et al. (2006) framework provides structure, the synthesis still reflects the analytical lens of the reviewer. Finally, most of the

included studies relied on cross-sectional designs and retrospective self-report, which limits the ability to draw causal conclusions or to understand how self-concept evolves longitudinally. The overrepresentation of clinically diagnosed and self-selecting participants also means the findings may not be generalisable to the entire adult ADHD population, particularly those who are undiagnosed or disengaged from services.

2.7.4 Clinical Implications and Future Research

Clinical Implications

The findings of this review have significant and actionable implications for clinical practice. The consistent finding that diagnosis can be a pivotal moment for self-concept highlights the clinical importance of providing structured post-diagnostic support that goes beyond symptom management to address identity reconstruction. Therapeutic approaches could benefit from integrating the principles of attribution theory and narrative therapy to help individuals make sense of their past experiences in light of their new diagnosis, reframing a lifetime of perceived failures as misunderstood neurodivergence. This process can be crucial in mitigating the grief and frustration that some individuals report post-diagnosis (Fleischmann & Fleischmann, 2012).

Furthermore, the evidence supporting strengths-based adaptation suggests that clinicians should actively work with clients to identify and leverage their strengths, in line with salutogenic and neurodiversity-affirmative practice. This could involve career counselling that helps individuals find environments where their cognitive style is an asset, or using strengths like creativity to develop novel solutions to daily challenges. For healthcare providers, including those within the NHS, these findings suggest that a more comprehensive ADHD assessment and intervention pathway is needed. Given the long waiting lists and focus on medication, integrating brief, identity-focused psychological interventions post-

diagnosis could be a valuable and efficient way to promote long-term well-being and self-acceptance.

Finally, the review's findings on masking (Godfrey-Harris & Shaw, 2023; Schrevel et al., 2016) underscore the need for interventions that support authentic self-expression. Clinicians can help clients understand the psychological cost of masking and develop the confidence to advocate for their needs in workplaces and educational settings, thereby reducing the emotional exhaustion and identity fragmentation associated with constantly trying to appear neurotypical.

Future Research

This review highlights several critical gaps in the literature that provide a clear roadmap for future research. First, there is a pressing need for longitudinal studies that track the evolution of self-concept from pre-diagnosis through to post-diagnostic adjustment and beyond. Such studies could clarify the causal relationships between diagnosis, self-concept, and life outcomes, and identify the factors that predict a more positive identity trajectory.

Second, research is needed to develop and validate standardised measures of adult ADHD self-concept that capture both deficit- and strengths-based dimensions. The methodological heterogeneity identified in this review limits the comparability of findings and hinders the field's progress. A robust, multi-dimensional measure would allow for more consistent and generalisable research.

Third, future studies should seek to include more diverse and representative samples. The current literature is dominated by studies from Western, educated, and clinically-referred populations. Research that actively recruits from different cultural backgrounds, socioeconomic strata, and gender identities is essential to developing a more intersectional

understanding of how these factors shape the experience of self-concept in adults with ADHD.

Finally, there is a need for intervention research that formally tests the efficacy of strengths-based and identity-focused therapies for this population. Randomised controlled trials comparing such approaches to standard, symptom-focused CBT could provide robust evidence to guide clinical practice and service development, ultimately helping to build a more holistic and effective model of care for adults with ADHD.

2.8 Conclusion

This SLR explored how adults with ADHD perceive their self-concept, synthesising deficit-based, strengths-based, and neurodiversity-informed perspectives. Findings highlight the impact of internalised stigma, masking, and external validation on self-perception, reinforcing the variability in how individuals navigate their ADHD identity. While many internalise negative societal narratives, others develop a more adaptive self-concept when supported by affirming environments. The review also identified key challenges in the field, including inconsistent measurement of self-concept, limited longitudinal research, and a lack of intersectional perspectives. Given these gaps, future research could benefit from a quantitative approach to understanding how ADHD adults internalise their strengths, offering greater clarity on the factors influencing self-perception and supporting the development of interventions that move beyond symptom management. Clinically, these findings suggest that ADHD interventions might incorporate identity-focused work, helping individuals process the emotional impact of diagnosis, unmasking, and self-acceptance. By synthesising existing literature and identifying future directions, this review contributes to the growing discourse on ADHD self-concept, reinforcing the need to reframe ADHD not solely as a deficit but as a diverse cognitive profile with the potential for positive identity development.

2.9 Rationale for Present Study

Taken together, the literature, theoretical perspectives, and national context point to a clear gap: while adult ADHD is increasingly recognised and treated, the lived experience of self - how individuals make sense of their diagnosis and construct their identities remains underexplored. Most existing research foregrounds impairment, with little attention to positive self-concept, perceived strengths, or the broader social context that shapes these narratives.

Recent qualitative studies (e.g., Sedgwick et al., 2019; Cook et al., 2014; Fleischmann & Fleischmann, 2012) have offered rich insights into how adults with ADHD understand their diagnosis and identity. These accounts highlight that some individuals reframe traits such as impulsivity, high energy, or divergent thinking as strengths, particularly in supportive environments. However, such research is largely qualitative and limited in sample size. Several authors explicitly call for larger-scale, quantitative studies to validate and expand on these themes.

This call for quantitative investigation is already beginning to be answered, highlighting the timeliness of the present study. For instance, in a recent multi-sample study, Katabi et al., (2023) developed and validated the Positive Attitudes Toward ADHD Scale (PATAS), one of the first robust measures to quantify positive self-perceptions in this population. Their work provides a crucial proof-of-concept that these positive attitudes can be reliably measured. However, their scale identified a single factor of general positivity, leaving a gap in understanding the specific *types* of strengths that contribute to this positive self-concept. This thesis therefore takes the next logical step: to develop a measure that does not just assess general positivity, but attempts to operationalise the specific, granular strength domains that have emerged from the qualitative literature.

This thesis responds to that call with a two-phase research design. First, a SLR synthesises the current empirical and theoretical literature on self-concept in adults with ADHD, drawing together qualitative and quantitative findings to map what is known and identify gaps. The review finds that, although negative self-concept and low self-esteem are well documented, quantitative research focused specifically on strengths within the adult ADHD self-concept remains scarce.

Accordingly, the second phase - the empirical study - focuses on strengths-based self-concept in a large sample of adults with ADHD, using a newly developed, empirically-driven measure of ADHD-related strengths. The study also examines how these self-perceptions relate to demographic variables such as gender, treatment status, and socioeconomic context, enabling a more robust and generalisable understanding of how adults with ADHD perceive their strengths.

Ultimately, the goal is to shift the narrative: rather than viewing ADHD purely as a problem to be fixed, this research asks what it means to live with ADHD, and how environments might better reflect the complexity and value of that experience. Like the alien in the prologue, we are challenged to see not just what is difficult, but also what is different and potentially valuable.

2.10 Research Aims

While theoretical and qualitative work increasingly highlights strengths in adults with ADHD, quantitative research in this area remains scarce. This empirical study represents a first step in addressing this gap. It details the development and preliminary evaluation of the ADHD Strengths Identification Questionnaire (ASIQ), a new measure grounded in the lived experiences of adults with ADHD.

In line with the reframing of this work as the first step in the process of validation, the study has the following aims:

1. To conduct a preliminary psychometric evaluation of the newly developed ADHD Strengths Identification Questionnaire (ASIQ) by exploring its underlying factor structure and internal consistency.

2. To describe the extent to which adults with ADHD in this sample identify with the strengths measured by the ASIQ.

3. To conduct an initial exploration of the relationships between self-perceived strengths and key demographic and clinical variables, including gender, educational attainment, socioeconomic context, and treatment history.

CHAPTER 3: METHOD

3.1 Design

This study employed a sequential exploratory mixed-methods design, a two-phase approach that is particularly well-suited for instrument development. This design, as outlined by Creswell & Clark (2007), begins with a qualitative phase to explore a phenomenon, followed by a quantitative phase to test or generalise the initial findings. The rationale for choosing this design was twofold. First, given the lack of existing quantitative measures for ADHD-related strengths, it was essential to first explore the construct qualitatively to ensure that any new instrument would be grounded in the authentic lived experiences of the target population. Second, the sequential nature of the design allows the qualitative findings to directly inform the development of the quantitative instrument, thereby strengthening its content and face validity.

In the first, qualitative phase of this study, themes related to ADHD strengths were systematically identified and synthesised from existing peer-reviewed qualitative literature. This process generated the conceptual foundation and initial item pool for the new instrument. The second, quantitative phase involved administering the newly developed instrument, the ADHD Strengths Identification Questionnaire (ASIQ), to a large sample of adults with ADHD and using exploratory factor analysis to evaluate its underlying structure and preliminary psychometric properties. This design ensures that the quantitative measure is empirically grounded in the lived experiences and qualitative understanding of the construct under investigation. The study was underpinned by a critical realist epistemological stance, which acknowledges that while ADHD has a neurobiological basis, its expression and meaning are shaped by social and cultural contexts.

3.2 Ethics

Ethical approval for this research project was obtained from the University of Hertfordshire's Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (Protocol Number: 0469 2024 Dec HSET; see Appendix C). NHS ethical approval was not required as recruitment was conducted via Reddit – an anonymous online message board. Participants volunteered to participate, and informed consent was secured from all individuals prior to data collection. Data was gathered using Qualtrics, a secure online survey platform approved by the University's ethics committee.

In accordance with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018 (DPA) (DPA, 2018), all data collected was stored securely on an encrypted, password-protected computer and the University's OneDrive secure cloud platform. Participants were informed of their right to withdraw at any point before electronically submitting their responses. However, they were made aware that, due to the anonymisation process, it would not be possible to withdraw their data after submission. Details of this process are outlined in the participant information sheet and consent form, provided in Appendix D and E, respectively. To promote inclusivity and acknowledge the potential discomfort of selecting 'Other' in demographic questions, open text fields were included to allow participants to self-identify characteristics such as gender and ethnicity. While initial ethical approval was granted, any subsequent changes to the survey, such as those informed by consultation with Experts by Experience, were approved through updated ethical review procedures.

3.3 Participants and Recruitment

3.3.1 Participants

To be eligible for the study, individuals had to be aged 18-65 years and reside in the UK. All participants were required to self-report a formal diagnosis of ADHD made by a qualified health professional under recognised diagnostic criteria (e.g. DSM-5 or ICD-10). Individuals were excluded if they reported any severe psychiatric comorbidities (e.g. psychosis, bipolar disorder, substance use disorder, or severe depressive illness) that could confound the reporting of strengths. Neurodevelopmental co-occurrences such as autism spectrum disorder were not grounds for exclusion unless they were accompanied by serious psychiatric difficulties. This approach was designed to reflect the heterogeneity of adult ADHD while ensuring that current severe mental health issues did not unduly influence self-report data.

3.3.2 Recruitment

A purposive, self-selecting sampling strategy was employed to recruit participants for the study. Recruitment was conducted online via the ADHDUK subreddit, a public UK-based forum where individuals with lived experience of ADHD share information, seek advice, and build community. A study advertisement was posted to this forum, briefly outlining the research aims and inviting users to access a survey link (see Appendix F). Upon following the link, individuals were presented with a participant information sheet and electronic consent form. Participation was entirely voluntary and anonymous. To encourage engagement, respondents were offered the chance to enter a prize draw to win one of six £25 vouchers (see Appendix G for details).

The recruitment window remained open for eight weeks and resulted in 310 initial responses. After data cleaning-removal of incomplete responses and exclusion based on predefined eligibility criteria-a final analytic sample of 167 participants was retained. All included participants provided full datasets and met the inclusion requirements.

The final sample ranged in age from 18 to 64 years (M = 40.64, SD = 10.66). The majority identified as female (74%), followed by male (21%) and non-binary or prefer-not-to-say (5%). Educational attainment was relatively high, with roughly two-thirds of participants reporting at least an undergraduate degree. Geographical data indicated broad representation across the UK. Socioeconomic status was estimated by mapping participants' self-reported city of residence to Index of Multiple Deprivation (IMD) tertiles.

3.4 Measures

3.4.1 Development of the ADHD Strengths Identification Questionnaire (ASIQ)

The ADHD Strengths Identification Questionnaire (ASIQ) was developed specifically for this study to provide an empirically grounded measure of strength-based characteristics in adults with ADHD. The development process was rigorous and systematic, following established best-practice guidelines for psychometric scale development (Boateng et al., 2018). This multi-stage process began with a comprehensive qualitative synthesis to generate an initial item pool, followed by item refinement and subsequent psychometric evaluation. This approach was chosen to ensure the final measure possessed strong content validity, being directly derived from the lived experiences of adults with ADHD as documented in peer-reviewed literature.

The initial development of the ASIQ was grounded in a qualitative synthesis of four key peer-reviewed studies that explored positive ADHD traits from the perspective of individuals with the condition: Nordby et al. (2023), Sedgwick et al. (2019), Fleischmann & Fleischmann (2012), and Mahdi et al. (2017). This foundational step ensured that the questionnaire items were not merely theoretical but reflected authentic, salient aspects of the ADHD experience. The subsequent quantitative phase aimed to establish the psychometric properties of the newly developed scale within a sample of 167 adults with a formal ADHD diagnosis.

ASIQ development followed published guidance for constructing and evaluating patient-reported measures, including item generation grounded in qualitative evidence, expert review, and preliminary psychometric testing (Boateng et al., 2018; DeVellis, 2016).

3.4.1.1 Stage 1: Item Generation via Qualitative Thematic Synthesis

The first stage in the ASIQ's development was focused on generating a pool of potential items by identifying core themes related to ADHD strengths from existing qualitative research. This process corresponds to the initial, critical phase of scale development, where the domain of interest is clearly defined and sampled (DeVellis, 2016).

Familiarisation and Initial Data Extraction.

To begin the analysis, the full text of each study was read in detail to gain a comprehensive understanding of the contexts and themes related to ADHD strengths. During this familiarisation process, all sections of the studies that discussed positive traits were systematically highlighted. These included participant quotes, thematic discussions, and researcher interpretations. The data were imported into NVivo software, which facilitated the organisation and traceability of the extracted segments. For example, Nordby et al. (2023) emphasised "resilience and growth," while Sedgwick et al. (2019) described traits such as "cognitive dynamism" and "divergent thinking." By annotating the data with contextual notes, the analysis preserved the original meaning of each excerpt and its relevance to the study's objectives.

Open Coding of Positive Traits

Following data extraction, the highlighted segments underwent open coding to capture their core meaning. This inductive process involved applying descriptive labels directly derived from the language used in the original studies. For instance, participant accounts of "thinking outside the box" were coded as "divergent thinking," and descriptions of "focusing intensely on tasks of interest" were coded as "hyper-focus." Each segment was

reviewed iteratively to ensure that the coding remained true to the source material. To enhance the reliability of the coding process, a second researcher reviewed a subset of the coded data, providing feedback and confirming the consistency of the applied codes.

Development of Broader Categories

Once the open coding was complete, related codes were grouped into broader categories that represented higher-order constructs. This process involved comparing and clustering codes based on their shared characteristics. For example, codes such as "creative thinking," "curiosity," and "problem-solving flexibility" were grouped under the category of "Cognitive Dynamism." Similarly, codes describing "perseverance" and "adapting to setbacks" were grouped into "Resilience."

Thematic Synthesis and Refinement

The broader categories were synthesised into preliminary themes, representing distinct strengths of ADHD. Themes were developed through an iterative process of comparing their defining features and cross-referencing them with the original studies' thematic frameworks. For example, "Cognitive Dynamism" emerged as a theme that encapsulated creative and adaptive thinking, drawing support from Sedgwick et al. (2019) and Fleischmann and Fleischmann (2012). Similarly, 'Hyper-focus' was identified as a separate theme, characterised by intense concentration on tasks of interest, as highlighted in Nordby et al. (2023). Preliminary themes were refined to ensure clarity and coherence, and a second researcher provided feedback to validate the thematic structure.

The final themes were defined in detail and documented in a codebook, which included operational definitions and illustrative examples. For instance, 'Resilience' was defined as the capacity to persevere and recover from setbacks, reflecting a growth-oriented mindset.

'Adventurousness' was described as a willingness to embrace novelty and risk, often resulting in unique experiences. The eight final themes identified were:

1. Creativity and Divergent Thinking
2. Hyperfocus
3. Energy and Dynamism
4. Socio-affective Skills
5. Resilience and Perseverance
6. Curiosity and Adventurousness
7. Cognitive Flexibility
8. Higher-Order Cognitive Skills

Reflexivity and Rigour

Throughout the thematic synthesis, reflexivity played a critical role in ensuring the transparency, credibility, and integrity of the analysis. Reflexive practices were integrated into every stage of the research process, including coding, theme development, and interpretation of findings. These practices not only enhanced the methodological rigour of the study but also provided an opportunity to critically examine the influence of the researcher's personal experiences and perspectives.

As a researcher with ADHD, personal reflexivity was particularly important. My lived experience of ADHD, including a deep understanding of its challenges and strengths, informed my engagement with the data. While this insider perspective offered unique insights into the nuances of ADHD-related strengths, I recognised the potential for bias in interpreting themes. For example, my personal familiarity with traits such as 'hyper-focus' and 'cognitive dynamism' may have heightened my sensitivity to these concepts during the coding process. To mitigate this, I documented my assumptions, expectations, and reflections in a reflexive journal, ensuring that my interpretations were grounded in the data rather than shaped solely by my personal experiences (see Appendix M).

This reflexivity extended to my approach to reverse-worded items during the survey development phase. Recognising that individuals with ADHD often struggle with ambiguous or overly abstract phrasing, I paid close attention to how reverse-worded items could be interpreted by participants. I reflected on my own cognitive patterns and sought feedback from experts by experience to ensure that the items were accessible and did not inadvertently cause confusion.

To further enhance rigour, the coding process was triangulated across the four studies, ensuring that the identified themes reflected consistent patterns within the broader dataset. Themes were also cross-validated against each individual study to confirm their applicability and consistency. For example, the theme "Resilience" was supported across all four studies but was explored through different terminologies and contexts, such as "growth after challenges" in Nordby et al. (2023) and "adapting under pressure" in Mahdi et al. (2017).

By integrating both personal and methodological reflexivity, this research not only maintained rigour but also highlighted the importance of transparency and critical reflection in understanding ADHD strengths. This dual approach ensured that the study's findings were both authentic and reliable, while acknowledging the unique perspective that an insider-researcher brings to the process.

3.4.1.2 Stage 2: Item Development and Scale Format

The second stage of this study involved developing the ADHD Strength Identification Questionnaire (ASIQ). This stage operationalised the qualitative synthesis into candidate items using established frameworks for scale development and early validation (Boateng et al., 2018; DeVellis, 2016; Clark & Watson, 1995). Item wording and survey formatting were guided by evidence-based principles for questionnaire design, including clarity, accessibility, and minimising respondent burden (Dillman et al., 2014; Krosnick & Presser, 2010). An iterative refinement process was used to review items for face validity and comprehensibility, ensuring alignment with the study aims.

Translation of Themes into Survey Items

Each of the eight core themes prioritised for the initial scale (Creativity and Divergent Thinking, Hyperfocus, Energy and Dynamism, Socio-affective Skills, Resilience and Perseverance, Curiosity and Adventurousness, Cognitive Flexibility, and Higher-Order Cognitive Skills) was translated into survey items that reflected their core attributes. The aim was to ensure that the items accurately captured the theoretical constructs while being phrased in language accessible to the target population. To achieve this, three items were generated for each theme, resulting in a total of 24 items. This step is crucial for ensuring the face validity and content validity of the measure, as items must clearly relate to the construct they are intended to measure (Boateng et al., 2018).

The item development process prioritised precision and balance. For example:

- For Cognitive Dynamism, items were designed to capture creativity and adaptability, such as: *"I often come up with unique or unconventional solutions to problems."*

- For Resilience, items reflected perseverance and recovery from setbacks, such as: *"I'm able to keep going, even when things get tough."*

- For Hyper-focus, items focused on intense, sustained attention, such as: *"When I'm interested in something, I can focus on it for hours without distraction."*

To reduce response bias and enhance reliability, a proportion of the items were reverse-worded. This strategy encouraged respondents to engage more thoughtfully with the questionnaire and mitigated the risk of acquiescence bias. For example, a reverse-worded item for Cognitive Dynamism was: "I rarely see more than one way to approach a situation," while a reverse-worded item for Resilience was: "I tend to give up easily when I face challenges."

Each item was designed to be rated on a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree, enabling a nuanced assessment of participants' identification with ADHD strengths.

3.5 EbE Review and Refinement

Consistent with a participatory ethos and our epistemological stance, we involved an Expert by Experience (EbE) - an adult with a diagnosis of ADHD - in the measure development process. After drafting the initial pool of questionnaire items (based on Phase 1 themes), we invited this individual to review the items and provide feedback. The expert commented on clarity, relevance, and tone of the items, ensuring that the wording was accessible and resonated with the lived experiences of adults with ADHD. Several refinements were made following this consultation: for example, one item originally phrased as *"I find it hard to sit still and prefer to stay active"* was identified as potentially ambiguous and was reworded for clarity.

The EbE also helped identify any inadvertent negative or stigmatising language - items were adjusted to maintain a positive, strengths-focused tone without downplaying the genuine challenges of ADHD. This iterative feedback process ensured the *ASIQ* had strong face validity and was grounded in real-world ADHD experiences. Beyond item wording, the consultation reinforced our reflexive approach, reminding the research team to remain mindful of our own biases and assumptions. All changes resulting from EbE input were submitted for ethics amendment and approved prior to data collection. This collaboration with an ADHD community member enhanced the measure's sensitivity and relevance, embodying a co-productive approach to research.

3.5.3 Adult ADHD Self-Report Scale (ASRS-v1.1)

The Adult ADHD Self-Report Scale (ASRS; Kessler et al., 2005) was included as a screening tool to increase the validity of ADHD self-reports in the online sample (See Appendix

I). Although participants were required to confirm a formal diagnosis of ADHD, the ASRS was used to cross-validate this self-report by assessing the presence and severity of current ADHD symptoms. This additional verification step aimed to reduce the risk of ineligible or inattentive participants responding inaccurately, a known limitation in online data collection.

The ASRS is an 18-item measure based on DSM-IV diagnostic criteria, with responses rated on a 5-point scale from 0 ("Never") to 4 ("Very often"). It has well-established psychometric properties, including strong internal consistency ($\alpha > .85$) and construct validity in adult ADHD populations. In the present study, ASRS responses were reviewed to ensure alignment between self-reported diagnosis and symptom expression, and data were screened for inconsistent or inattentive responding.

3.5.4 Demographics and Clinical Characteristics

Participants were asked to complete a short set of questions designed to capture key demographic and clinical information (see Appendix J). The demographic data included participants' age, gender, ethnicity, highest level of education, occupational status, and city of residence. These variables were selected to allow for a detailed characterisation of the sample and to enable exploratory analyses examining whether identification with ADHD strengths varied across sociodemographic groups.

In addition to general background information, participants were asked to report whether they had received a formal diagnosis of ADHD from a qualified professional and whether they were currently receiving any form of treatment for the condition. Treatment-related responses included the use of prescribed ADHD medication, engagement in psychological therapy, or no treatment. These clinical variables were included to contextualise participants' experiences and to explore how diagnostic and treatment status might relate to the identification of strengths.

3.6 Procedure

3.6.1 Survey Administration

Participants completed the study via a secure online platform (Qualtrics). Upon clicking the study link, they were first presented with a Participant Information Sheet, which outlined the study aims, confidentiality terms, voluntary nature of participation, and contact details for the research team. This was followed by an electronic consent form. Participants who did not consent were automatically exited from the survey.

Upon providing consent, participants proceeded through the following blocks:

1. *Demographic and Screening Questions*

   Participants provided demographic information (e.g., age, gender, ethnicity, education level, employment status, and city of residence) and completed ADHD-specific screening questions. These included confirmation of a formal ADHD diagnosis, year of diagnosis, treatment history, presence of psychiatric comorbidities (used for exclusion), and belief in the existence of ADHD-related strengths.

2. *Randomised Measures Block*

   The main psychometric measures-the ASRS, and ASIQ were presented in randomised order using Qualtrics' Block Randomiser.

   This randomisation was implemented to reduce order effects and response bias, ensuring that responses to any one measure were not systematically influenced by the measures preceding it. This is particularly important in psychological survey research, where fixed ordering can unintentionally prime certain types of self-perception (Podsakoff et al., 2003). Furthermore, Item order was randomised to reduce potential order and context effects (e.g., priming and acquiescence patterns) and to distribute any such bias evenly across participants,

consistent with recommendations in survey methodology (Dillman et al., 2014; Krosnick & Presser, 2010).

ASIQ

In one of the randomised blocks, participants completed the 24-item ASIQ, developed through the sequential exploratory process detailed in the Measures section. Items were scored on a 5-point Likert scale from "Strongly disagree" to "Strongly agree," with a balanced number of positively and reverse-worded items.

Adult ADHD Self-Report Scale (ASRS-v1.1)

In another randomised block, participants completed the 18-item ASRS-v1.1, assessing current symptom severity and presentation over the previous six months.

3. *Signposting and Debrief*

    After completing the measures, participants were shown a debrief page thanking them for their contribution and signposting them to relevant support services, including ADHD-specific organisations and general mental health resources (see Appendix K). As participation was anonymous, no data could be withdrawn after submission.

4. *Prize Draw (Optional)*

    Following completion, participants were offered the opportunity to enter a separate, unlinked prize draw to win one of six £25 Love2Shop vouchers. A new, standalone survey link was used for this purpose to ensure that personal contact details remained unconnected to survey responses. This separation upheld participant anonymity and complied with ethical data handling standards.

3.7 Data Cleaning and Preparation

A total of 310 individuals identifying as adults with an ADHD diagnosis initially completed the survey. Prior to analysis, a comprehensive data cleaning process was undertaken

to ensure data quality and appropriateness for statistical procedures such as exploratory factor analysis (EFA), parametric testing, and ordinal regression.

Removal of Incomplete and Invalid Responses

The first stage of data cleaning involved removing cases with substantial missing data across the core measures. Incomplete entries were defined as those missing entire pages of the ASIQ or failing to complete key demographic variables. Additional exclusions were applied for invalid response patterns, such as straight-lining (e.g., selecting the same answer for all items), which may indicate inattentive or non-purposeful responding. After these steps, 169 complete and valid cases remained.

Identification and Exclusion of Multivariate Outliers

To satisfy the assumption of multivariate normality required for exploratory factor analysis, we conducted an outlier check using Mahalanobis distance across the 24 ASIQ items. Using a conservative threshold ($p < .001$, χ^2 distribution), two multivariate outliers were identified and excluded from subsequent analyses. The final analytic sample comprised 167 participants.

Reverse-Scoring of Negatively Worded Items

The ASIQ comprised 24 items, each rated on a five-point Likert scale from 1 ("Strongly Disagree") to 5 ("Strongly Agree"), designed to capture endorsement of perceived strengths. Several items were negatively worded (e.g., *"I often find it difficult to come up with different ways of seeing a situation"*), requiring reverse scoring prior to further analysis. Reversals were handled using the standard transformation ($1{\rightarrow}5$, $2{\rightarrow}4$, $3{\rightarrow}3$, $4{\rightarrow}2$, $5{\rightarrow}1$), ensuring that higher scores consistently reflected stronger identification with the underlying strengths. This step was critical to avoid artefactual factor separation by item polarity, particularly given the

attentional difficulties often experienced by individuals with ADHD, which may increase the risk of response error when interpreting reversed items (Podsakoff et al., 2003).

Inspection of Item-Level Distributions

Following reverse scoring, the distribution of each ASIQ item was inspected to verify appropriate scale usage and variability. All items demonstrated broad response variation across the 5-point scale, with no items exhibiting floor or ceiling effects. This supported the suitability of the data for inclusion in exploratory factor analysis and indicated that participants were engaging with items as intended.

Treatment of Demographic Variables

To support planned subgroup analyses and regression modelling, several demographic variables were recoded into binary or ordinal formats. Educational attainment was initially collected on a 5-point ordinal scale ranging from 1 ("No formal qualifications") to 5 ("Postgraduate degree"). For analysis purposes, this variable was binarised into two categories: pre-university (score $\leq$ 3, corresponding to GCSEs, A-Levels, or equivalent) and post-university (score $\geq$ 4, corresponding to undergraduate degree or higher). This distinction was informed by prior educational attainment research suggesting that the transition to and beyond university-level education marks a meaningful difference in socioeconomic, occupational, and psychological outcomes (Blanden et al., 2007). Codifying education in this way also ensured adequate statistical power by avoiding overly granular subgroups.

A similar approach was taken with treatment status. Participants were asked whether they were currently receiving any treatment for ADHD, including stimulant medication, coaching, or psychological therapy. Responses were recoded into a binary variable: "In

Treatment" and "Not in Treatment". This permitted group comparisons and modelling of how treatment engagement related to strength identification.

Calculation and Binning of Socioeconomic Deprivation (IMD)

Socioeconomic status was estimated using the Index of Multiple Deprivation (IMD), derived from UK national datasets. Participants provided their city or local authority, which was used to match them to official 2019 IMD scores for those areas. IMD scores represent relative area-level deprivation, with higher values indicating greater deprivation (Ministry of Housing, Communities and Local Government, 2019). IMD data were successfully matched for n=130 participants. These scores were then binned into tertiles, creating three approximately equal-sized groups: Low Deprivation, Medium Deprivation, and High Deprivation. This grouping allowed the exploration of whether area-level deprivation predicted participants' identification with strengths.

Construction of Composite Variables

After conducting Exploratory Factor Analysis (EFA) (described in the next section), two internally consistent subscales emerged: Cognitive Adaptability (5 items) and Creative-Divergent Thinking (7 items). Composite scores were computed by averaging the item scores within each factor. In line with recommended psychometric practices, we computed both total scores and grouped categorical variables for use in descriptive comparisons and ordinal regression. Specifically, participants were divided into three categories for each factor based on tertiles of total scores:

- Weak identification (lowest third)
- Moderate identification (middle third)

- Strong identification (highest third)

This trichotomous classification enabled the use of ordinal logistic regression to assess whether demographic variables predicted the strength of identification with each of the two constructs.

3.8 Data Analysis Strategy

All statistical analyses were conducted using IBM SPSS Statistics (Version 29). The analysis proceeded in two distinct phases: a preliminary psychometric evaluation of the ASIQ using Exploratory Factor Analysis (EFA), followed by descriptive and inferential analyses to explore demographic relationships.

3.8.1 Exploratory Factor Analysis

To examine the underlying factor structure of the ASIQ, an Exploratory Factor Analysis (EFA) was conducted on the 24-item pool. Principal Axis Factoring (PAF) was selected as the extraction method because the data violated the assumption of multivariate normality (Fabrigar et al., 1999). An oblique rotation (Direct Oblimin) was employed, based on the theoretical expectation that dimensions of ADHD strengths (e.g., creativity and adaptability) would likely be correlated rather than orthogonal.

The suitability of the data for factor analysis was assessed using the Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy and Bartlett's Test of Sphericity. A KMO value of .60 or higher and a statistically significant Bartlett's test ($p < .05$) were set as the minimum thresholds for proceeding with analysis (Kaiser, 1974).

To determine the number of factors to retain, three criteria were applied:

1. **Eigenvalues:** Factors with eigenvalues greater than 1.0 (Kaiser's criterion).

2. **Scree Plot Inspection:** Visual analysis of the scree plot to identify the point of inflection.

3. **Interpretability:** The theoretical coherence and interpretability of the extracted factors.

Item retention was guided by statistical magnitude and conceptual clarity. Items were generally retained if they possessed a primary factor loading of $\geq$ .40. Items with significant cross-loadings (difference < .20 between primary and secondary loadings) or low communalities (< .30) were candidates for removal, subject to theoretical review. Internal consistency for the resulting subscales was assessed using Cronbach's alpha, with values > .70 considered acceptable for early-stage scale development (DeVellis, 2016).

3.8.2 Scale Scoring and Cut-Offs

After the final factor structure was established, subscale scores were computed by averaging the items within each factor (after reverse-scoring negatively worded items), preserving the original 1–5 response metric.

Because the ASIQ is a newly developed measure and no validated clinical thresholds currently exist, exploratory cut-offs were created by dividing each subscale distribution into tertiles representing weak, moderate and strong identification. This sample-relative categorisation was used to support ordinal modelling and interpretability, and findings based on these cut-offs were treated as hypothesis-generating.

3.8.3 Subgroup and Demographic Analyses

Composite scores for the identified factors were calculated by averaging the relevant item scores. To address the third research aim, the relationships between these strength scores

and demographic variables (gender, education, treatment status, and socioeconomic deprivation) were examined.

Independent samples t-tests were used for binary comparisons (e.g., gender, education level), and one-way ANOVAs were used for variables with three or more groups (e.g., deprivation tertiles). Given the exploratory, hypothesis-generating nature of this study, a formal correction for multiple comparisons (such as the Bonferroni correction) was not applied. While this increases the risk of Type I errors, applying strict corrections in preliminary research can elevate the risk of Type II errors, potentially masking subtle signals that warrant future investigation (Tabachnick & Fidell, 2019). Consequently, findings from these subgroup analyses should be interpreted as tentative signals requiring replication.

Finally, ordinal logistic regression models were constructed to determine if any demographic variables acted as unique predictors of strength endorsement when controlling for one another. For these models, composite scores were binned into tertiles (weak, moderate, and strong identification) to satisfy the assumptions of ordinal regression.

3.8.4 Combined Exploratory Model

To explore whether any demographic or clinical variable had a unique association with strengths identification when considered simultaneously, an exploratory combined model was conducted for each ASIQ factor, entering gender, education, treatment status and IMD tertile together. This analysis was intended as an initial multivariable check on patterns observed in univariable subgroup analyses.

CHAPTER 4: RESULTS

Research Aim 1: Factor Structure and Internal Consistency of the ASIQ

4.1.1 Exploratory Factor Analysis (EFA)

An exploratory factor analysis was conducted on the 24 ASIQ items in line with the analytic approach outlined in Section 3.8.1. The dataset was confirmed as suitable for factor analysis. The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was .794, and Bartlett's Test of Sphericity was statistically significant, $\chi^2(276) = 1050.46$, $p < .001$ (see Table 4).

Initial factor extraction yielded a seven-factor solution with eigenvalues > 1. However, inspection of the scree plot (Figure 2) indicated a distinct inflection point after the second component. Consequently, a two-factor solution was examined. A three-factor solution was also tested but resulted in weak item loadings and poor internal reliability, leading to the rejection of that model.

Table 4: Factor Analysis Suitability using KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy		0.794
Bartlett's Test of Sphericity	Approx. Chi-Square	1050.460
	df	276
	Sig.	P<0.005

Figure 2: Scree Plot of Eigenvalues for 24-Item ASIQ
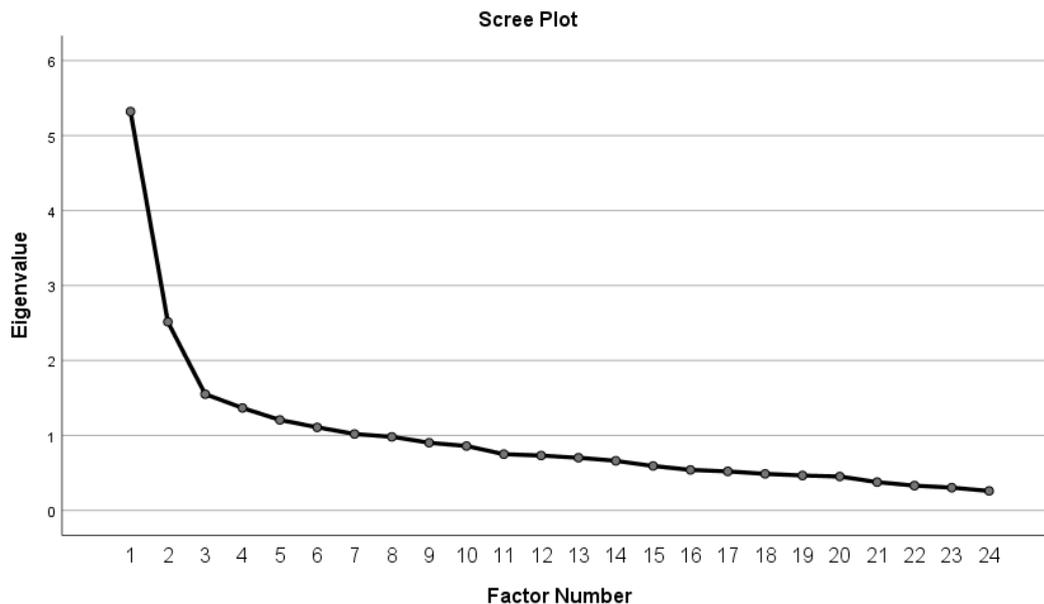
4.1.2 Final Factor Structure and Reliability

After an iterative process of refinement to maximise internal consistency and theoretical clarity, a final two-factor solution comprising 12 items was retained, as seen in Table 5. Most retained items had factor loadings above 0.40 on their primary factor and minimal cross-loadings, suggesting a reasonably simple structure (Tabachnick & Fidell, 2019).

Table 5: ASIQ 24-item Pattern Matrix

Pattern Matrix		
	Factor	
	1	**2**
Q3	-0.579	
Q13	-0.578	
Q15	-0.729	
Q20	-0.494	
Q24	-0.526	
Q1		0.714
Q2	0.464	0.417
Q4		0.326
Q6		0.345

Q14	0.381	0.330
Q19	0.331	0.573
Q22		0.579

The two factors identified were labelled as follows:

Factor 1: Cognitive Adaptability

This factor appeared to capture an individual's self-perceived ability to reframe challenges, persist through difficulty, and adjust flexibly when plans change. All five items comprising this subscale were negatively worded and subsequently reverse-scored. Internal consistency for this 5-item subscale was acceptable (Cronbach's α =.715).

Q3: "If my first idea doesn't work, I tend to struggle with trying a different approach" (reverse scored)

Q13: "When I face a setback, I tend to lose motivation to keep trying" (reverse scored)

Q15: "If my plans don't work out, I find it hard to adapt and try a new approach" (reverse scored)

Q20: "I often struggle to adjust when plans change unexpectedly" (reverse scored)

Q24: "When faced with complex information, I find it hard to break it down into simpler components" (reverse scored)

Factor 2: Creative-Divergent Thinking

This factor seemed to represent self-perceptions of creativity, originality, perspective-taking, pattern recognition, and immersive attention (hyperfocus). Internal consistency for this 7-item subscale was also acceptable (Cronbach's α =.703). The seven items included:

Q1: "I frequently think of ideas that others might find unusual or unexpected"

Q2: "I often find it difficult to come up with different ways of seeing a situation" (reverse scored)

Q4: "When I'm interested in something, I can get so absorbed that I lose track of time or forget to take breaks"

Q6: "When something fully captures my attention, I tend to ignore distractions around me"

Q14: "In difficult situations, I often feel a sense of hope about finding a solution"

Q19: "I am able to see situations from multiple perspectives without much effort"

Q22: "I often notice patterns and connections that others might overlook"

The specific decisions regarding item retention and factor assignment were guided by a combination of statistical indicators and theoretical coherence, in line with best practices for early-scale development (Clark & Watson, 1995). For instance, Items 4 and 6, which both relate to 'hyperfocus,' were retained in Factor 2 (Creative-Divergent Thinking) despite having loadings slightly below the .40 cutoff. They were deemed essential to the conceptual completeness of that factor, capturing the immersive attention aspect of creativity. Notably, removing either item 4 or 6 did not substantially improve the factor's internal consistency (Cronbach's α), so their inclusion was justified to preserve the breadth of content covered by this subscale.

In cases where an item showed cross-loading between factors, a careful conceptual determination was made. Item 2 (reverse-scored: "I often find it difficult to come up with different ways of seeing a situation") was ultimately assigned to Factor 2 because its content directly taps into divergent thinking - a core component of the Creative-Divergent Thinking construct - and it is less relevant to the themes of perseverance and adaptability that define Factor 1. Similarly, Item 14 ("In difficult situations, I often feel a sense of hope about finding a solution") was assigned to Factor 2. While *hope* can be related to adaptability (and thus could have been linked with Factor 1), its inclusion in the Creative-Divergent Thinking factor reflects the idea that seeing novel solutions is often underpinned by an optimistic outlook. These judgment calls in item placement, made during this exploratory analysis, were necessary to maintain theoretical clarity. However, they also highlight the need for subsequent confirmatory analyses with a refined scale, as discussed in Chapter 5.

The EFA supported a two-factor structure for the ASIQ, comprising Cognitive Adaptability (5 items) and Creative-Divergent Thinking (7 items).

4.2 Research Aim 2: Descriptive Analysis of Strength Endorsement

4.2.1 Descriptive Statistics

Descriptive statistics for the ASIQ subscales are presented in Table 6.

Table 6: Descriptive statistics for ASIQ subscales

Subscale	Mean	SD	Skewness	Kurtosis
Cognitive Adaptability	3.42	0.74	-0.38	-0.310
Creative-Divergent Thinking	4.21	0.51	-0.53	0.021

Note: Scores range from 1 ("Not at all true of me") to 5 ("Very true of me").

On average, participants endorsed items in both domains, with relatively higher endorsement on the Creative-Divergent Thiinking subscale compared to Cognitive Adaptability (Table 6).

4.3 Research Aim 3: Exploring Relationships with Demographic Variables

Associations between ASIQ factor scores and demographic or clinical variables were examined using the approach outlined in Section 3.8.3. Results are presented below for each demographic and clinical variable.

Gender: As shown in Table 7, there was no significant difference in Cognitive Adaptability scores between male (M = 3.42, SD = 0.69) and female participants (M = 3.43, SD = 0.77), t(157) = -0.07, p = .948. In contrast, for Creative-Divergent Thinking, a statistically significant difference was observed, t(157) = -3.03, p = .003. Female participants reported significantly higher levels of self-identified creative strengths (M = 4.14, SD = 0.54) compared to male participants (M = 3.83, SD = 0.52).

Table 7: t-test Results by Gender

Factor	Gender	*n*	M	SD	*t*(df)	*p*	Mean Difference	95% CI of Difference
Cognitive Adaptability	Male	35	3.42	0.69	-0.07			[-0.29, 0.27]
	Female	124	3.43	0.77	(157)	0.948	-0.009	

Creative-Divergent Thinking	Male	35	3.83	0.52	-3.03 (157)	.003**	-0.312	[-0.52, -0.11]
	Female	124	4.14	0.54				

Education: As detailed in Table 8, a significant effect of education was found for Cognitive Adaptability, $t(165) = 3.89$, $p < .001$. Participants whose education did not extend beyond secondary school reported significantly higher self-identification with adaptability strengths ($M = 3.70$, $SD = 0.63$) than those who had completed post-university education ($M = 3.26$, $SD = 0.75$). No significant difference was observed between education groups on the Creative-Divergent Thinking subscale, $t(165) = -1.88$, $p = .063$. This may indicate that the Cognitive Adaptability factor is sensitive to life experiences associated with different educational paths.

Table 8: t-test Results by Educational Attainment

Group Statistics					
Factor	Education	N	Mean	Std. Deviation	Std. Error Mean
Cognitive Adaptability	Below Undergraduate	62	3.7000	0.63427	0.08055
	Above Undergraduate	105	3.2590	0.74881	0.07308
Creative-Divergent Thinking	Below Undergraduate	62	3.9862	0.62976	0.07998
	Above Undergraduate	105	4.1497	0.48743	0.04757

Treatment Status and Deprivation: As shown in Table 9, independent samples t-tests indicated no significant differences in scores on either subscale between participants who had received ADHD-related treatment and those who had not ($p > .50$ for both). Similarly, a one-way ANOVA, summarised in Table 10, found no significant differences in scores on either subscale across low, medium, and high deprivation groups ($p > .19$ for both). This suggests that, in this sample, the ASIQ's performance was not significantly influenced by participants' treatment history or socioeconomic context.

Table 9: t-test Results by Treatment Status

Factor Subscale	Treatment Group	Mean	SD	t(df)	p	Mean Difference
Cognitive Adaptability	No Treatment	3.41	0.76	-0.03	0.975	-0.004
	Treatment	3.42	0.74	(161)		
Creative-Divergent Thinking	No Treatment	4.04	0.53	-0.56	0.576	-0.054
	Treatment	4.09	0.56	(161)		

A one-way ANOVA was conducted to examine the effect of deprivation on participants' identification with ADHD-related strengths. For the Cognitive Adaptability subscale, no significant differences were found between low, medium, and high deprivation groups, $F(2, 127) = 0.02$, $p = .981$. Similarly, no significant differences were observed for the Creative-Divergent Thinking subscale, $F(2, 127) = 1.63$, $p = .199$.

Table 10: One-way ANOVA for Deprivation Impact

Factor Subscale	SS Between Groups	SS Within Groups	df Between	df Within	MS Between	MS Within	F	p
Cognitive Adaptability	0.022	75.215	2	127	0.011	0.592	0.02	.981
Creative-Divergent Thinking	1.045	40.629	2	127	0.522	0.320	1.63	.199

Combined Exploratory Model

In the combined exploratory models for each ASIQ factor, no predictor (gender, education, treatment status, or IMD tertile) emerged as statistically significant when entered simultaneously (see Appendix K).

CHAPTER 5: DISCUSSION

This chapter provides an interpretation of the findings from the empirical study, situating them within the context of the revised research aims and the broader literature. The discussion begins with an overview of the key findings related to the development and preliminary evaluation of the ADHD Strengths Identification Questionnaire (ASIQ). It then explores the theoretical and methodological implications of the emergent two-factor structure, relates the findings to existing research, and critically reflects on the learnings from this initial stage of measure development. Finally, the chapter outlines the study's strengths and limitations, considers its preliminary clinical implications, and proposes a detailed, multi-stage plan for future research required to further validate the ASIQ.

5.1 Overview of Key Findings

This study represents a first step in the development and validation of a new measure designed to assess self-perceived strengths in adults with ADHD. The primary aim was to explore the psychometric properties of the ASIQ, a novel instrument grounded in qualitative literature. The exploratory factor analysis suggested that the 24 initial items could be parsimoniously reduced to a 12-item measure with a plausible two-factor structure. These two factors, which demonstrated acceptable preliminary internal consistency, were interpreted as 'Cognitive Adaptability' (reflecting flexibility and perseverance) and 'Creative-Divergent Thinking' (reflecting originality, hyperfocus, and curiosity).

Descriptive analysis of the measure's performance in this sample indicated that participants tended to endorse items on the Creative-Divergent Thinking subscale quite strongly, while endorsement of Cognitive Adaptability was more moderate, albeit still positive. A preliminary exploration of the measure's relationship with demographic variables suggested that the ASIQ may be sensitive to certain contextual factors. Specifically, scores on

the Creative-Divergent Thinking subscale appeared to differ by gender, with female participants endorsing these items more strongly than male participants. Scores on the Cognitive Adaptability subscale appeared to differ by educational attainment, with participants who had not completed university-level education endorsing these items more strongly. In this sample, the measure's scores did not appear to be significantly influenced by socioeconomic deprivation or treatment history.

Notably, when all demographic variables were entered together in a single regression model, none remained a significant predictor of ASIQ scores. This reinforces that the differences detected (by gender and education) were small in magnitude - once we account for their shared and confounding effects, no factor had a strong unique impact. This outcome is consistent with the exploratory, hypothesis-generating nature of our analyses: some "significant" findings from individual tests may in fact reflect minor effects or chance variation. For an initial validation study, this highlights the need for caution - the ASIQ appears largely consistent across groups in this sample, and any subgroup trends would need to be verified with larger samples and more controlled analyses.

5.2 Interpretation of the Two-Factor Structure

The consolidation of the initial eight qualitative themes into a two-factor structure is a key finding of this preliminary study. This parsimonious structure may suggest a potential overlap among the original themes or limitations in their distinctiveness in practice. For instance, the qualities of creativity, hyperfocus, and cognitive flexibility may be so interrelated in the lived experience of ADHD that they coalesce into a single broad 'Creative-Divergent Thinking' factor. This aligns with qualitative research by Sedgwick et al. (2019), who identified a core theme of 'cognitive dynamism' that encompassed these very traits. Similarly, traits like resilience and perseverance may have naturally merged into the 'Cognitive Adaptability' factor.

The moderate negative correlation (r = -.31) between the two factors is intriguing. Substantively, it could hint at somewhat divergent 'profiles' of ADHD strengths; for example, some individuals may excel at generating novel ideas but feel less adaptable to unexpected change, and vice versa. However, as will be discussed in the methodological reflections, this correlation may also be a partial artefact of the measure's design. Nonetheless, the emergence of these two broad domains provides a clear and potentially useful framework for conceptualising self-perceived strengths in this population.

5.3 Relevance of Findings to Existing Literature and Theoretical Frameworks

The findings from this preliminary evaluation both reinforce and significantly extend the emerging literature on ADHD strengths, and can be interpreted through several key theoretical lenses. The two-factor solution of Cognitive Adaptability and Creative-Divergent Thinking aligns closely with themes reported in prior qualitative studies. Sedgwick et al. (2019), for example, documented six positive themes in adults with ADHD, notably including 'cognitive dynamism' and 'resilience.' Cognitive dynamism - a construct encompassing quick, non-linear thinking, originality, and hyperfocus, maps directly onto our Creative-Divergent Thinking factor, while resilience in the face of challenges parallels our Cognitive Adaptability factor. Similarly, a recent thematic analysis by Nordby et al. (2023) described 'the unconventional mind' as a core positive experience of ADHD, characterised by creativity and thinking outside the norm, alongside themes of perseverance and growth. Our quantitative results provide initial empirical support for these narratives, suggesting that adults with ADHD do indeed self-identify with these distinct domains of strength. In essence, what previous qualitative research told us anecdotally, that many with ADHD see themselves as imaginative, flexible thinkers who can thrive in the right conditions, have now captured in a measurable form.

The high overall endorsement of Creative-Divergent Thinking in our sample is especially notable in light of broader creativity research. ADHD has often been linked to increased divergent thinking and innovative potential (Hoogman et al., 2020). Prior studies have found that individuals with ADHD tend to generate more original ideas than neurotypical controls and report more real-world creative achievements (Pasarín-Lavín et al., 2024). Our finding that most participants saw themselves as highly creative and able to hyperfocus supports these observations from the self-perception angle. It aligns with White & Shah's (2006) seminal work showing that adults with ADHD scored higher on certain creativity measures than those without ADHD, and it echoes evidence that ADHD traits like distractibility, curiosity, and mind-wandering can foster creative thinking. The prevalence of a strong creative self-concept in our sample suggests that for many adults with ADHD, being inventive and 'thinking outside the box' is not just a stereotype but a lived reality. This finding directly supports the neurodiversity paradigm, which posits that neurological differences are not inherently pathological but represent natural variations that can confer advantages in specific contexts (Swanepoel, 2024).

Our analysis of demographic influences adds new nuances to the literature. The finding that female participants endorsed Creative-Divergent Thinking strengths more strongly than males is particularly noteworthy. In the general population, research on gender and creativity has often shown trivial or no mean differences (Taylor et al., 2023). One possible interpretation lies in the different ways ADHD manifests and is internalised across genders. Women with ADHD are more likely to present with inattentive symptoms and may go undiagnosed for longer, potentially leading them to cultivate and recognise creative aptitudes as a coping mechanism or a valid form of self-expression (Oroian et al., 2024). Through the lens of the "looking-glass self" (Cooley, 1902), the divergent social feedback could lead to differences in self-concept: girls who escape early stigma might nurture their

creative identity, whereas boys who are reprimanded for off-task imaginative antics might not label those behaviours as creativity. This aligns with qualitative observations that women with ADHD often speak of masking and finding alternative outlets for their inattentive traits, potentially cultivating self-regard in creative domains (Bradley et al., 2025). Notably, recent clinical studies have begun to acknowledge subtle gender differences in adult ADHD presentations - for instance, women report more self-esteem impairments linked to chronic masking (Craddock, 2024). It is plausible that, conversely, women also may acknowledge certain strengths (like creativity) more readily. Future research should explore this further, but our finding suggests that gender norms and socialisation (rather than any inherent ability difference) may influence whether ADHD individuals identify with creative strengths.

This finding can be contextualised through the insights gathered in the systematic literature review. The SLR highlighted that women with ADHD often experience intense pressure to mask their symptoms and conform to social expectations (Godfrey-Harris & Shaw, 2023; Schrevel et al., 2016). It is plausible that this experience of navigating a world not designed for them fosters a greater reliance on, and therefore a greater awareness of, creative and divergent thinking as a necessary adaptation. Furthermore, the finding by Mörstedt et al. (2015) that women with ADHD show higher concordance between self- and informant-ratings may suggest a heightened level of self-awareness or introspection, which could lead to a more confident endorsement of their creative strengths.

The finding that participants with lower formal education reported higher Cognitive Adaptability scores is counterintuitive when compared to general population literature, where greater educational attainment is often associated with improved cognitive flexibility (Hamtiaux & Houssemand, 2012). In our ADHD sample, the opposite pattern emerged. One interpretation is that adults with ADHD who did not pursue higher education may have been 'hardened in the crucible' of real-world demands, developing practical adaptive skills and

perseverance out of necessity. This finding challenges assumptions that adaptability is solely a product of formal cognitive training and suggests it may be a skill forged through lived experience. From a self-concept theory perspective (Rogers, 1959), these individuals may have had more opportunities to receive positive feedback for their real-world problem-solving, thereby integrating "adaptability" into their self-schema more strongly than those in academic settings where their struggles may have been more salient.

Finally, it is notable that neither socioeconomic status nor ADHD treatment history had significant impacts on strength identification in our sample. The lack of an SES effect suggests that recognising ADHD-related strengths is not merely a luxury of the privileged; adults across various economic backgrounds reported strengths in equal measure. This aligns with a salutogenic perspective (Antonovsky, 1987), which focuses on the internal and external resources that promote health despite adversity. Our findings suggest that a positive self-concept of one's strengths can act as a key internal resource, independent of external socioeconomic factors. Likewise, the absence of a treatment effect implies that these positive self-conceptions can arise naturally and are not solely a product of clinical intervention. This resonates with recent evidence that even untreated adults with ADHD can exhibit high creativity and real-world achievements (Stolte et al., 2022).

5.4 Methodological Reflections and Learnings from the ASIQ's Development

A key learning from this initial stage of developing the ASIQ relates to the interpretation of its two-factor structure and the moderate negative correlation observed between the factors. While one interpretation is that there are two distinct and slightly competing profiles of ADHD strengths, a more critical, methodological explanation must also be considered. All five items retained in the Cognitive Adaptability factor were negatively worded and subsequently reverse-scored. In contrast, five of the seven items in the Creative-Divergent Thinking factor were positively worded. It is therefore possible that the factor

structure is partially a 'method effect' or 'wording artefact,' where participants' response styles to negative versus positive framing influenced the clustering of items. This could create an artificial distinction between the factors and contribute to the negative correlation.

This possibility represents a significant learning from this preliminary validation study. It highlights the need to re-test the factor structure using a revised version of the ASIQ that includes a balanced set of positively and negatively worded items for both constructs. This would help to determine whether the two-factor structure reflects a genuine conceptual distinction or is an artefact of item design. This finding underscores the importance of careful item construction in psychometric development, particularly for neurodivergent populations who may process negatively worded items differently.

5.5 Strengths of the Study

While this study must be viewed as a preliminary and exploratory step in a longer validation process, it possesses several key strengths that contribute to the literature on adult ADHD and provide a solid foundation for future research.

Methodological Rigour and Novel Measure Development

A primary strength of this study is its response to a significant gap in the literature: the lack of quantitative tools for assessing self-perceived strengths in adults with ADHD. By developing the ASIQ, this research provides a novel instrument that moves beyond anecdotal evidence and begins to operationalise positive self-concept in a measurable way. The use of a sequential exploratory mixed-methods design is a particular strength. Grounding the initial item pool in a systematic synthesis of qualitative literature ensures that the measure has strong content validity; the items are not merely theoretical but are derived directly from the lived experiences and language of adults with ADHD.

Furthermore, the inclusion of an Expert by Experience (EbE) review in the refinement process enhances the measure's face validity and relevance. This participatory approach ensured that the item wording was clear, accessible, and resonated authentically with the target population, reducing the risk of academic jargon or misinterpretation. This rigorous, multi-stage development process - from qualitative synthesis to expert review to statistical exploration - represents a best-practice approach to psychometric tool development and increases confidence in the conceptual foundation of the ASIQ.

Community-Recruited Sample and Analytical Approach

The study's recruitment from a large, online ADHD community forum is another strength. While not a random sample, it allowed for the collection of data from a diverse group of individuals across the UK who are actively engaged in making sense of their ADHD identity. This provides a valuable snapshot of self-perception outside of a purely clinical context, where participants might be in acute distress. The analytical approach was also robust; the use of Exploratory Factor Analysis was appropriate for this initial stage of measure development, and the subsequent group comparisons provided valuable preliminary insights into the measure's performance across different demographic groups.

Researcher Positionality and Reflexivity

The primary researcher's positionality as an individual with an ADHD diagnosis can be considered a methodological strength. This "insider perspective" provided a nuanced understanding of the lived experience that informed the item development process and the interpretation of the findings, helping to ensure the research remained grounded and authentic. This subjectivity was carefully balanced with objective, data-driven methods and

continuous reflexive practice, as documented in the reflexive journal (see Appendix M). For instance, the initial surprise and disappointment when the EFA yielded only two factors, rather than the eight anticipated from the qualitative synthesis, was a moment of critical reflexivity. It forced a letting go of preconceived notions and an embrace of what the data revealed, strengthening the objectivity of the final interpretation. This balance between empathetic insight and empirical rigour aims to enhance the trustworthiness of the research.

5.6 Limitations of the Study

Despite its strengths, this study has several important limitations that must be acknowledged when interpreting the findings. These limitations relate to the sample, the reliance on self-report, the specific constraints of the measure itself, and the cross-sectional design.

Sampling Bias and Generalisability

The use of a self-selecting, online volunteer sample introduces significant potential for bias. Participants were recruited from a forum dedicated to ADHD, suggesting they are likely more engaged, knowledgeable, and perhaps more self-accepting of their diagnosis than the general adult ADHD population. This means our findings likely represent a more optimistic view of ADHD strengths and cannot be generalised to all adults with the condition, particularly those who are not online, are disengaged from support communities, or who hold a purely deficit-focused view of their condition.

Furthermore, the sample had a significant gender imbalance, with a large majority of participants identifying as female. While this may reflect the demographics of online support communities, it limits the generalisability of our findings, especially those related to gender.

The significant difference we observed with women reporting higher creative strengths, should be interpreted with caution given the small number of male respondents.

Reliance on Self-Report

The study relied exclusively on self-report measures. While this is appropriate for assessing *self-perception*, it is susceptible to several biases. Social desirability bias may have led participants to over-endorse strengths, as the study was framed in a positive light. There is also the possibility of a positive illusory bias, a tendency observed in some individuals with ADHD to overestimate their abilities in certain domains. Without corroborating evidence from informant reports (e.g., from partners or colleagues) or objective performance-based measures (e.g., tests of creativity or problem-solving), we cannot know how well these self-perceptions map onto actual behaviours or abilities. The study validly captures participants' internal narratives of strength, but these narratives may not be an entirely accurate reflection of their objective capabilities.

Measurement Constraints and the Wording Artefact

The ASIQ itself has limitations in its current form. A significant concern is the potential 'wording artefact' in the factor structure. All five items in the 'Cognitive Adaptability' factor were negatively worded and subsequently reverse-scored. It is plausible that this shared wording format, rather than just the conceptual content, caused these items to cluster together. This could also partially explain the negative correlation between the two factors; participants may have developed a response set, agreeing with the positively worded 'Creative-Divergent Thinking' items and disagreeing with the negatively worded 'Cognitive Adaptability' items. This represents a critical learning from this study and means the two-factor structure must be considered provisional until it can be replicated with a revised scale that has a balanced set of positively and negatively worded items for both constructs.

Additionally, the ASIQ is limited by construct underrepresentation. It primarily captures two cognitive domains of strength. Other important potential strengths identified in the qualitative literature, such as empathy, humour, social intelligence, and high energy, did not form coherent factors and were largely excluded from the final 12-item scale. Therefore, the ASIQ provides a narrow, rather than exhaustive, profile of possible ADHD strengths.

Cross-Sectional Design and Unmeasured Variables

The study's cross-sectional design means that no causal inferences can be drawn. For example, while we found an association between lower educational attainment and higher self-reported adaptability, we cannot determine the direction of this relationship. It is equally plausible that navigating life without the structure of higher education fosters adaptability, or that individuals who are inherently more adaptable are less likely to pursue traditional academic paths.

Finally, the study did not formally assess for comorbid mental health conditions, such as anxiety or depression, which are highly prevalent in the adult ADHD population and could significantly influence self-perception. A participant experiencing a depressive episode, for instance, would likely under-report their strengths due to negative cognitive biases. Similarly, we did not screen for co-occurring autistic traits. Given the significant overlap between ADHD and autism, and the fact that some traits associated with autism (e.g., cognitive rigidity) are the inverse of strengths measured here (e.g., cognitive adaptability), the presence of undiagnosed autistic traits in our sample could have confounded the results. Future research should control for these variables to gain a clearer understanding of the unique contribution of ADHD to self-perceived strengths.

5.7 Clinical Implications

While it must be emphasised that the ASIQ is an exploratory instrument and is not ready for clinical use, the preliminary findings from this study offer valuable insights into potential future directions for clinical practice with adults with ADHD. The implications discussed here are speculative and contingent on the successful completion of the rigorous, multi-stage validation process outlined in the following section.

Potential for Enhancing Post-Diagnostic Support

The findings suggest the potential utility of a structured, strengths-based framework in post-diagnostic support. If the two emergent factors of Cognitive Adaptability and Creative-Divergent Thinking are confirmed in future validation studies, they could offer a more nuanced way to guide psychoeducation. Rather than discussing 'ADHD strengths' in the abstract, clinicians might one day use such a framework to help newly diagnosed adults explore these specific domains. A validated tool grounded in these concepts could potentially help individuals build a more balanced self-narrative that integrates both challenges and assets, fostering self-acceptance and a more complete understanding of their cognitive profile. This aligns with attribution theory, helping the individual to shift their self-narrative from one of personal failing to one of neurobiological difference.

Informing Future Strengths-Focused Interventions

This study's findings also point towards a potential direction for strengths-based assessment and intervention. A future, fully validated version of the ASIQ, or similar tools, could be used to facilitate therapeutic conversations that move beyond a sole focus on deficits. Such an approach would allow clinicians to identify and leverage a client's inherent strengths within therapy. For example, if a client were to score highly on a validated measure of Creative-Divergent Thinking, a therapist might consider exploring more creative, non-

linear therapeutic approaches. Similarly, a high score on Cognitive Adaptability could suggest that a client might respond well to strategies that build on their inherent resilience. This approach is not intended to replace work on impairments, but to complement it, potentially leading to a more integrated and hopeful therapeutic process.

Considerations for Future Service Design

Finally, these preliminary findings may offer a rationale for the future development of targeted psychological interventions. Should the ASIQ's factors prove robust, services could potentially design post-diagnostic psychoeducation groups focused on identity integration, using the concepts of Cognitive Adaptability and Creative-Divergent Thinking as a curriculum. Furthermore, the insights on masking and its costs, as highlighted in the systematic review, reinforce the importance of therapeutic work that explicitly addresses this phenomenon, supporting clients in developing the confidence for authentic self-expression and self-advocacy.

5.8 Future Research Directions

The present study represents the first crucial step in the development of the ASIQ. The findings are preliminary, and a rigorous, multi-stage process of validation is required before the scale can be confidently used in research or clinical settings. This section outlines a detailed roadmap for this future research, with each proposed step directly addressing the limitations and building upon the learnings of the current study. The overarching goal is to move from this initial exploratory phase to a comprehensive validation that establishes the ASIQ as a robust and reliable measure of self-perceived strengths in adults with ADHD.

The most immediate and critical next step is to test the stability of the two-factor structure identified in this thesis. Exploratory Factor Analysis (EFA), by its nature, is a hypothesis-generating technique; it suggests a potential underlying structure but does not

confirm it. The 'learnings' from our EFA, particularly the potential 'wording artefact' where all 'Cognitive Adaptability' items were negatively phrased, necessitate a replication that addresses this methodological concern. Therefore, the first priority is to conduct a Confirmatory Factor Analysis (CFA) on a new, independent sample, using a revised version of the instrument. This would involve rephrasing the five negatively worded 'Cognitive Adaptability' items into positively worded statements to create a balanced measure and mitigate the risk of a method effect. This revised scale would then be administered to a new, larger, and more demographically diverse replicant sample of adults with ADHD. The data from this new sample would be used to conduct a CFA, which would formally test the hypothesis that the two-factor structure ('Cognitive Adaptability' and 'Creative-Divergent Thinking') provides a good fit to the new data. A successful CFA, indicated by strong model fit indices, would provide strong evidence for the stability and robustness of the factor structure, giving us confidence that these two domains are a valid representation of self-perceived strengths in this population.

Once the factor structure is confirmed, the next step is to build a body of evidence for the measure's construct validity - the extent to which the ASIQ truly measures the theoretical concepts of 'Cognitive Adaptability' and 'Creative-Divergent Thinking'. This involves demonstrating that the ASIQ behaves as expected in relation to other, established psychological measures. To assess convergent validity, the ASIQ should be correlated with external measures of theoretically similar constructs. For example, to validate the 'Creative-Divergent Thinking' subscale, participants could complete the ASIQ alongside established measures of creativity, such as the Torrance Tests of Creative Thinking, and a self-report measure of the Big Five personality trait of 'Openness to Experience'. To validate the 'Cognitive Adaptability' subscale, it could be correlated with measures of psychological resilience and cognitive flexibility. Finding the expected strong, positive correlations would

provide compelling evidence that our subscales are measuring the constructs they claim to measure. Simultaneously, it would be crucial to establish discriminant validity by demonstrating that the ASIQ subscales have low or non-significant correlations with measures of unrelated constructs. This is vital for proving that the ASIQ is not simply a measure of general well-being or positive affect. For instance, we would hypothesise a low correlation between the ASIQ subscales and a measure of social conformity, or a non-significant correlation with a measure of conscientiousness, a trait often impaired in ADHD and conceptually distinct from the strengths measured here. Demonstrating these low correlations would provide evidence that the ASIQ is a distinct and specific measure of ADHD-related strengths.

Beyond theoretical coherence, a useful measure must have criterion validity - its scores must correspond to real-world, concrete outcomes or criteria. This step is essential for establishing the practical utility of the ASIQ. One way to assess this is through concurrent validity, often tested using the known-groups method, which examines whether the ASIQ can differentiate between groups that are known to possess the relevant strengths. Based on our findings and the broader literature, we would hypothesise that individuals in highly creative or entrepreneurial professions (e.g., artists, designers, start-up founders) would score significantly higher on the 'Creative-Divergent Thinking' subscale compared to a control group from more conventional professions. A study designed to test this would provide powerful evidence for the measure's concurrent validity.

Arguably the most powerful form of validation is predictive validity, which assesses whether ASIQ scores can predict future outcomes. A longitudinal study could be designed where a cohort of adults with ADHD (e.g., university students or new employees) completes the ASIQ at baseline. Their outcomes would then be tracked over a period of time. We would hypothesise that higher baseline scores on 'Cognitive Adaptability' would predict successful

adaptation to the new environment (e.g., higher grades, better job performance reviews, lower dropout rates). Similarly, we would hypothesise that higher baseline scores on 'Creative-Divergent Thinking' might predict innovative contributions (e.g., number of creative projects completed, positive supervisor ratings on innovation). Establishing such predictive links would provide a compelling rationale for using the ASIQ in clinical or coaching settings to identify individuals' potential.

Reflecting on the limitations and specific findings of this thesis, further research should also explore the more nuanced aspects of the ASIQ's performance. Our study found preliminary evidence of gender and education differences in subscale scores; future research with larger, more balanced samples should investigate these differences further, specifically by testing for measurement invariance across genders to ensure that the ASIQ is measuring the same underlying constructs in the same way for men and women. Furthermore, our study was limited by not formally assessing for comorbid conditions. Future validation studies should include measures of anxiety, depression, and autistic traits to examine how these conditions influence self-perceived strengths and to establish the ASIQ's validity independent of these co-occurring factors. Lastly, to address the limitations of self-report, a multi-method study could be conducted that combines the ASIQ with informant reports (e.g., from partners or colleagues) and objective, performance-based tests of creativity and cognitive flexibility. This would allow us to explore the relationship between an individual's self-perception of their strengths and their demonstrated ability in those areas.

Finally, a fascinating research by Katabi et al. (2023) provides a compelling new direction for this line of inquiry. In a robust, multi-sample study, they found that while greater inattentive symptom severity predicted *less* positive attitudes toward ADHD, greater hyperactive/impulsive symptom severity actually predicted *more* positive attitudes. This suggests that the two core symptom clusters of ADHD may have a very different relationship

with an individual's self-concept. A crucial next step would be to investigate whether the two strength domains identified by the ASIQ are differentially related to these symptom profiles. For instance, is 'Creative-Divergent Thinking' more strongly associated with the hyperactive/impulsive domain, while 'Cognitive Adaptability' is more closely linked to the experience of managing inattentive challenges? Answering this question would add significant depth to our understanding of how specific ADHD traits are reframed as strengths and would represent a powerful integration of this thesis's findings with the latest developments in the field.

By systematically undertaking these validation steps, from confirming the factor structure to establishing robust construct and criterion validity, a strong body of evidence can be built to support the ASIQ as a reliable and valid measure of self-perceived strengths in adults with ADHD. This foundational work is essential before the measure can be confidently used to advance our understanding and support of this population.

5.9 Conclusion

This thesis began with a thought experiment: an alien observer viewing human cognitive variation without a preconceived notion of 'disorder.' The research that followed was an attempt to move closer to that neutral, curious gaze by systematically exploring the self-perceived strengths of adults with ADHD. The findings from both the systematic literature review and the empirical study offer a compelling, evidence-based counter-narrative to the historically dominant deficit model. They suggest that the very neurocognitive differences that define ADHD can also be the source of significant, self-perceived strengths that are an intrinsic part of an individual's identity.

The systematic review established that while the literature is replete with accounts of the struggles associated with ADHD, a consistent, albeit smaller, body of evidence points to a parallel reality of resilience, creativity, and positive adaptation. It highlighted a critical gap:

the lack of quantitative tools to systematically measure these positive self-perceptions. The empirical study was a direct response to this gap. In developing and conducting a preliminary evaluation of the ADHD Strengths Identification Questionnaire (ASIQ), this research successfully undertook the crucial first steps in operationalising these strengths. The emergence of a coherent two-factor structure - 'Cognitive Adaptability' and 'Creative-Divergent Thinking' - provides a promising, empirically-grounded framework for understanding and measuring these positive dimensions of the ADHD experience.

The findings from the ASIQ suggest that for many adults with ADHD, identifying with strengths is not an exception, but a common part of their self-concept. This study provides preliminary evidence that these self-perceptions are not merely a by-product of socioeconomic advantage or clinical treatment, but appear to be a more fundamental aspect of the lived experience, influenced in nuanced ways by factors like gender and educational history. This work, therefore, contributes a vital piece to the puzzle of adult ADHD identity. It provides a 'proof of concept' that strengths can be reliably measured and offers a methodological roadmap for the future research that is essential to fully validate the ASIQ.

Ultimately, this research reinforces that ADHD is not a monolithic disorder of deficit. It is a complex, dual-sided neurotype, characterised by a unique profile of both challenges and potential advantages. Acknowledging this duality does not mean romanticising the condition or invalidating the very real impairments it can cause. Rather, it means embracing a more complete and compassionate understanding of the whole person. It means recognising that the same mind that struggles with focus in a lecture may be capable of extraordinary hyperfocus on a passion project; that the same impulsivity that leads to social errors can also fuel courageous, unconventional thinking.

Returning to our alien observer, they might conclude that this particular subset of human brains is optimised for innovation and adaptation in dynamic environments, even if it is

poorly suited to static, bureaucratic ones. From this perspective, the "problem" of ADHD is not located solely within the individual, but in the mismatch between their cognitive style and the rigid expectations of many modern institutions. The work of clinicians, educators, and researchers, therefore, is not just to 'fix' the individual, but to help build bridges between different neurotypes and to create environments where a wider range of cognitive styles can flourish.

In conclusion, this thesis contributes to a more inclusive and empirically-grounded narrative for adult ADHD. It validates the lived experience of countless individuals who have long felt that their diagnosis did not tell their whole story. By providing a preliminary tool and a clear direction for future inquiry, this research helps to shift the scientific and clinical conversation from a singular focus on what is "wrong" with the ADHD brain, to a more balanced exploration of what is different, what is challenging, and, crucially, what is strong. This concluding insight - that difference contains its own strengths - is both the ending of this research and a beginning of a more inclusive narrative for ADHD, one in which those who once felt *alien* might finally feel at home.

REFERENCES

Antonovsky, A. (1987). *Unraveling the Mystery of Health: How People Manage Stress and Stay Well*. Jossey-Bass.

Antshel, K. M., Faraone, S. V., & Gordon, M. (2014). Cognitive behavioral treatment outcomes in adolescent ADHD. *Journal of Attention Disorders*, *18*(6), 483–495. https://doi.org/10.1177/1087054712443155

Armanda Hamtiaux & Claude Houssemand. (2012). Adaptability, Cognitive Flexibility, Personal Need for Structure, and Rigidity. *Journal of Psychology Research*, *2*(10). https://doi.org/10.17265/2159-5542/2012.10.001

Asherson, P., Leaver, L., Adamou, M., Arif, M., Askey, G., Butler, M., Cubbin, S., Newlove-Delgado, T., Kustow, J., Lanham-Cook, J., Findlay, J., Maxwell, J., Mason, P., Read, H., van Rensburg, K., Müller-Sedgwick, U., Sedgwick-Müller, J., & Skirrow, C. (2022). Mainstreaming adult ADHD into primary care in the UK: Guidance, practice, and best practice recommendations. *BMC Psychiatry*, *22*(1), 640. https://doi.org/10.1186/s12888-022-04290-7

Barkley, R. A. (1997). *ADHD and the nature of self-control* (pp. xix, 410). The Guilford Press.

Barkley, R. A. (2006). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment, 3rd ed* (pp. xiv, 770). The Guilford Press.

Barkley, R. A., & Brown, T. E. (2008). Unrecognized attention-deficit/hyperactivity disorder in adults presenting with other psychiatric disorders. *CNS Spectrums*, *13*(11), 977–984. https://doi.org/10.1017/s1092852900014036

Beaton, D. M., Sirois, F., & Milne, E. (2022). Experiences of criticism in adults with ADHD: A qualitative study. *PloS One*, *17*(2), e0263366. https://doi.org/10.1371/journal.pone.0263366

Bhaskar, R. (1978). On the Possibility of Social Scientific Knowledge and the Limits of Naturalism. *Journal for the Theory of Social Behaviour*, *8*(1), 1–28. https://doi.org/10.1111/j.1468-5914.1978.tb00389.x

Biederman, J. (2017). *INTERNATIONAL CONSENSUS STATEMENT ON ADHD To the Editor: I am writing in hopes of alerting your extensive readership to the recent publication of the International Consensus Statement on attention-deficit/hyperactivity disorder (ADHD)*. https://consensus.app/papers/international-consensus-statement-on-adhd-to-the-editor-i-biederman/2a0f20d9139b5725b9e3444c981def3d/

Blais, J., Polanczyk, G., Danese, A., Wertz, J., Moffitt, T., & Arseneault, L. (2016). Persistence, Remission and Emergence of ADHD in Young Adulthood: Results from a Longitudinal, Prospective Population-Based Cohort. *JAMA Psychiatry*. https://consensus.app/papers/persistence-remission-and-emergence-of-adhd-in-young-blais-polanczyk/248204b5ada55657b035d3c259041b29/

Blanden, J., Gregg, P., & Macmillan, L. (2007). Accounting for Intergenerational Income Persistence: Noncognitive Skills, Ability and Education. *The Economic Journal*, *117*(519), C43–C60. https://doi.org/10.1111/j.1468-0297.2007.02034.x

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best Practices for Developing and Validating Scales for Health, Social, and Behavioral Research: A Primer. *Frontiers in Public Health*, *6*. https://doi.org/10.3389/fpubh.2018.00149

Bradley, S., Parzych, I., Platts, J., & Powell, L. (2025). Understanding and harnessing differences in women with ADHD: A qualitative study. *Neurodiversity*, *3*, 27546330251317199. https://doi.org/10.1177/27546330251317199

Canu, W. H., Newman, M. L., Morrow, T. L., & Pope, D. L. W. (2008). Social appraisal of adult ADHD: Stigma and influences of the beholder's Big Five personality traits. *Journal of Attention Disorders*, *11*(6), 700–710. https://doi.org/10.1177/1087054707305090

Chapman, R., & Botha, M. (2023). Neurodivergence-informed therapy. *Developmental Medicine and Child Neurology*, *65*(3), 310–317. https://doi.org/10.1111/dmcn.15384

Clark, L. A., & Watson, D. (1995). Constructing validity: Basic issues in objective scale development. *Psychological Assessment*, *7*(3), 309–319. https://doi.org/10.1037/1040-3590.7.3.309

Cook, J., Knight, E., Hume, I., & Qureshi, A. (2014). The self-esteem of adults diagnosed with attention-deficit/hyperactivity disorder (ADHD): A systematic review of the literature. *ADHD Attention Deficit and Hyperactivity Disorders*, *6*(4), 249–268. Scopus. https://doi.org/10.1007/s12402-014-0133-2

Cooley, C. H. (1902). The Looking-Glass Self. *Social Media*.

Corrigan, P. W., & Shapiro, J. R. (2010). Measuring the impact of programs that challenge the public stigma of mental illness. *Clinical Psychology Review*, *30*(8), 907–922. https://doi.org/10.1016/j.cpr.2010.06.004

Craddock, E. (2024). Being a Woman Is 100% Significant to My Experiences of Attention Deficit Hyperactivity Disorder and Autism: Exploring the Gendered Implications of an Adulthood Combined Autism and Attention Deficit Hyperactivity Disorder Diagnosis. *Qualitative Health Research*, *34*(14), 1442–1455. https://doi.org/10.1177/10497323241253412

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research* (pp. xviii, 275). Sage Publications, Inc.

Crook, T., & McDowall, A. (2023). Paradoxical career strengths and successes of ADHD adults: An evolving narrative. *Journal of Work-Applied Management*, *16*(1), 112–126. https://doi.org/10.1108/JWAM-05-2023-0048

Dalrymple, R. A., Maxwell, L. M., Russell, S., & Duthie, J. (2020). NICE guideline review: Attention deficit hyperactivity disorder: diagnosis and management (NG87). *Archives of Disease in*

Childhood - Education and Practice, *105*(5), 289–293.

https://doi.org/10.1136/archdischild-2019-316928

DeVellis, R. F. (2016). *Scale Development: Theory and Applications*. SAGE Publications.

Diagnosis and treatment of attention deficit hyperactivity disorder (ADHD). (1998). *NIH Consensus Statement*, *16 2*, 1–37.

Diagnostic and statistical manual of mental disorders: DSM-5™, 5th ed (pp. xliv, 947). (2013). American Psychiatric Publishing, Inc.

https://doi.org/10.1176/appi.books.9780890425596

Dillman, D. A., Smyth, J. D., & Christian, L. M. (2014). Internet, phone, mail, and mixed-mode surveys: The tailored design method (4th ed.). Wiley.

Dittner, A. J., Hodsoll, J., Rimes, K. A., Russell, A. J., & Chalder, T. (2018). Cognitive-behavioural therapy for adult attention-deficit hyperactivity disorder: A proof of concept randomised controlled trial. *Acta Psychiatrica Scandinavica*, *137*(2), 125–137.

https://doi.org/10.1111/acps.12836

Doshi, J. A., Hodgkins, P., Kahle, J., Sikirica, V., Cangelosi, M. J., Setyawan, J., Erder, M. H., & Neumann, P. J. (2012). Economic impact of childhood and adult attention-deficit/hyperactivity disorder in the United States. *Journal of the American Academy of Child and Adolescent Psychiatry*, *51*(10), 990-1002.e2.

https://doi.org/10.1016/j.jaac.2012.07.008

Eke, H., Ford, T., Newlove-Delgado, T., Price, A., Young, S., Ani, C., Sayal, K., Lynn, R. M., Paul, M., & Janssens, A. (2020). Transition between child and adult services for young people with attention-deficit hyperactivity disorder (ADHD): Findings from a British national surveillance study. *The British Journal of Psychiatry*, *217*(5), 616–622.

https://doi.org/10.1192/bjp.2019.131

Erlandsson, S. I., Hornborg, C., Sorbring, E., & Dauman, N. (2022). Is ADHD a way of conceptualizing long-term emotional stress and social disadvantage? *Frontiers in Public Health*, *10*, 966900. https://doi.org/10.3389/fpubh.2022.966900

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999). *Evaluating the Use of Exploratory Factor Analysis in Psychological Research*.

Fleischmann, A., & Fleischmann, R. H. (2012). Advantages of an ADHD diagnosis in adulthood: Evidence from online narratives. *Qual. Health Res.*, *22*(11), 1486–1496. https://doi.org/10.1177/1049732312457468

Full guideline – September 2008 | Attention deficit hyperactivity disorder: Diagnosis and management | Guidance | NICE. (2018, March 14). NICE. https://www.nice.org.uk/guidance/ng87/evidence/full-guideline-september-2008-4783651310?tab=evidence

Ginapp, C. M., Macdonald-Gagnon, G., Angarita, G. A., Bold, K. W., & Potenza, M. N. (2022). The lived experiences of adults with attention-deficit/hyperactivity disorder: A rapid review of qualitative evidence. *Frontiers in Psychiatry*, *13*, 949321. https://doi.org/10.3389/fpsyt.2022.949321

Godfrey, E., Fuermaier, A., Tucha, L., Butzbach, M., Weisbrod, M., Aschenbrenner, S., & Tucha, O. (2020). Public perceptions of adult ADHD: Indications of stigma? *Journal of Neural Transmission*, *128*, 993–1008. https://doi.org/10.1007/s00702-020-02279-8

Godfrey-Harris, M., & Shaw, S. C. K. (2023). The experiences of medical students with ADHD: A phenomenological study. *PLoS ONE*, *18*(8 August). Scopus. https://doi.org/10.1371/journal.pone.0290513

Hannes, K., & Macaitis, K. (2012). A move to more systematic and transparent approaches in qualitative evidence synthesis: Update on a review of published papers. *Qualitative Research*, *12*(4), 402–442. https://doi.org/10.1177/1468794111432992

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*(1), 31. https://doi.org/10.1186/s12888-015-0410-4

Health and Care of People with Learning Disabilities, Experimental Statistics 2022 to 2023. (2023). NHS England Digital. Retrieved 5 May 2025, from https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2022-to-2023

Hechtman, L., Weiss, G., & Perlman, T. (1980). Hyperactives as young adults: Self-esteem and social skills. *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie*, *25*(6), 478–483. https://doi.org/10.1177/070674378002500603

Holmquist, J. P., Nordby, E. S., & Nøvik, T. S. (2023). ADHD as difference: Perspectives on diagnosis and identity among adults diagnosed in adulthood. *Scandinavian Journal of Psychology*, *64*(2), 144–153.

Hoogman, M., Stolte, M., Baas, M., & Kroesbergen, E. (2020). Creativity and ADHD: A review of behavioral studies, the effect of psychostimulants and neural underpinnings. *Neuroscience & Biobehavioral Reviews*, *119*, 66–85. https://doi.org/10.1016/j.neubiorev.2020.09.029

Jousselin, C. M. (2018). Caring Enough to Wait: Bureaucratic Care and Waiting Time Standards in an NHS clinic for Adults with ADHD. *Anthropology Matters*, *18*(1). https://doi.org/10.22582/am.v18i1.497

Kaiser, H. F. (1974). An index of factorial simplicity. *Psychometrika*, *39*(1), 31–36. https://doi.org/10.1007/BF02291575

Katabi, G., merav, Lukito, S., Sonuga-Barke, E., & Shahar, N. (2023). *Positive attitudes towards ADHD among diagnosed individuals: Divergent influences across symptoms*. OSF. https://doi.org/10.31234/osf.io/p3sw6

Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., Howes, M. J., Jin, R., Secnik, K., Spencer, T., Ustun, T. B., & Walters, E. E. (2005). The World Health Organization Adult ADHD Self-Report Scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine*, *35*(2), 245–256. https://doi.org/10.1017/s0033291704002892

Kessler, R. C., Adler, L., Barkley, R., Biederman, J., Conners, C. K., Demler, O., Faraone, S. V., Greenhill, L. L., Howes, M. J., Secnik, K., Spencer, T., Ustun, T. B., Walters, E. E., & Zaslavsky, A. M. (2006). The prevalence and correlates of adult ADHD in the United States: Results from the National Comorbidity Survey Replication. *The American Journal of Psychiatry*, *163*(4), 716–723. https://doi.org/10.1176/ajp.2006.163.4.716

Knouse, L. E., & Mitchell, J. T. (2015). Incautiously optimistic: Positively valenced cognitive avoidance in adult ADHD. *Cognitive and Behavioral Practice*, *22*(2), 192–202. https://doi.org/10.1016/j.cbpra.2014.06.003

Knouse, L. E., Sprich, S. E., Cooper-Vince, C. E., & Safren, S. (2009). Attention-Deficit/Hyperactivity Disorder Symptom Profiles in Medication-Treated Adults Entering a Psychosocial Treatment Program. *Journal of ADHD & Related Disorders*, *1 1*, 34–48.

Kooij, S. J., Bejerot, S., Blackwell, A., Caci, H., Casas-Brugué, M., Carpentier, P. J., Edvinsson, D., Fayyad, J., Foeken, K., Fitzgerald, M., Gaillac, V., Ginsberg, Y., Henry, C., Krause, J., Lensing, M. B., Manor, I., Niederhofer, H., Nunes-Filipe, C., Ohlmeier, M. D., … Asherson, P. (2010). European consensus statement on diagnosis and treatment of adult ADHD: The European Network Adult ADHD. *BMC Psychiatry*, *10*(1), 67. https://doi.org/10.1186/1471-244X-10-67

Krosnick, J. A., & Presser, S. (2010). Question and questionnaire design. In P. V. Marsden & J. D. Wright (Eds.), Handbook of survey research (2nd ed., pp. 263–314). Emerald.

Landis, J. R., & Koch, G. G. (1977). The measurement of observer agreement for categorical data. *Biometrics*, *33*(1), 159–174.

Lasky, A. K., Weisner, T. S., Jensen, P. S., Hinshaw, S. P., Hechtman, L., Arnold, L. E., Murray, D., & Swanson, J. M. (2016). ADHD in context: Young adults' reports of the impact of occupational environment on the manifestation of ADHD. *Social Science & Medicine (1982)*, *161*, 160–168. https://doi.org/10.1016/j.socscimed.2016.06.003

Lee, Y. S. (2020). The Past Four Years Research Work of the Adult Attention-Deficit/Hyperactivity Disorder Special Interest Group in the Korean Academy of Child and Adolescent Psychiatry. *Journal of the Korean Academy of Child and Adolescent Psychiatry*, *31*(1), 3–4. https://doi.org/10.5765/jkacap.190031

Lloyd, G., Stead, J., & Cohen, D. (Eds). (2006). *Critical New Perspectives on ADHD*. Routledge. https://doi.org/10.4324/9780203008010

Long, H. A., French, D. P., & Brooks, J. M. (2020). Optimising the value of the critical appraisal skills programme (CASP) tool for quality appraisal in qualitative evidence synthesis. *Research Methods in Medicine & Health Sciences*, *1*(1), 31–42. https://doi.org/10.1177/2632084320947559

Mahdi, S., Viljoen, M., Massuti, R., Selb, M., Almodayfer, O., Karande, S., De Vries, P. J., Rohde, L., & Bölte, S. (2017). An international qualitative study of ability and disability in ADHD using the WHO-ICF framework. *European Child & Adolescent Psychiatry*, *26*(10), 1219–1231. https://doi.org/10.1007/s00787-017-0983-1

Marron, B., & McKeown, L. (2024). "Thoroughly out of my depth - A quality improvement project to improve junior clinician's confidence in undertaking adult ADHD clinic appointments. *European Psychiatry*, *67*(Suppl 1), S794–S795. https://doi.org/10.1192/j.eurpsy.2024.1655

Martin, J. (2017). © *Joanna Briggs Institute 2017   Critical Appraisal Checklist for Systematic Reviews and Research Syntheses*.

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*(1), 184. https://doi.org/10.1186/1472-6963-13-184

McKechnie, D. G. J., O'Nions, E., Dunsmuir, S., & Petersen, I. (2023). Attention-deficit hyperactivity disorder diagnoses and prescriptions in UK primary care, 2000–2018: Population-based cohort study. *BJPsych Open*, *9*(4), e121. https://doi.org/10.1192/bjo.2023.512

Miklósi, M., Kovács, B., Janovicz, J., Lelki, F., & Kassai, R. (2024). Adult attention-deficit/hyperactivity symptoms and parental cognitions: A meta-analysis. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1321078

Mörstedt, B., Corbisiero, S., Bitto, H., & Stieglitz, R.-D. (2015). Attention-Deficit/Hyperactivity Disorder (ADHD) in Adulthood: Concordance and Differences between Self- and Informant Perspectives on Symptoms and Functional Impairment. *PloS One*, *10*(11), e0141342. https://doi.org/10.1371/journal.pone.0141342

Newark, P. E., Elsässer, M., & Stieglitz, R.-D. (2016). Self-Esteem, Self-Efficacy, and Resources in Adults With ADHD. *Journal of Attention Disorders*, *20*(3), 279–290. https://doi.org/10.1177/1087054712459561

Newark, P. E., & Stieglitz, R.-D. (2010). Therapy-relevant factors in adult ADHD from a cognitive behavioural perspective. *ADHD Attention Deficit and Hyperactivity Disorders*, *2*(2), 59–72. https://doi.org/10.1007/s12402-010-0023-1

Nordby, E. S., Guribye, F., Nordgreen, T., & Lundervold, A. J. (2023). Silver linings of ADHD: A thematic analysis of adults' positive experiences with living with ADHD. *BMJ Open*, *13*(10), e072052. https://doi.org/10.1136/bmjopen-2023-072052

Olson, C. A. (2013). Conflict of Interest and Evaluation Research: Should We Do Effectiveness Studies of Our Own Educational Programs? *Journal of Continuing Education in the Health Professions*, *33*(4), 203. https://doi.org/10.1002/chp.21192

Oroian, B. A., Costandache, G., Popescu, E., Nechita, P., & Szalontay, A. (2024). The uncharted territory of female adult ADHD: A comprehensive review. *European Psychiatry*, *67*(Suppl 1), S299–S300. https://doi.org/10.1192/j.eurpsy.2024.624

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *International Journal of Surgery*, *88*, 105906. https://doi.org/10.1016/j.ijsu.2021.105906

Data Protection Act 2018 [Text]. Statute Law Database. Retrieved 30 May 2025, from https://www.legislation.gov.uk/ukpga/2018/12

Pasarín-Lavín, T., García, T., Abín, A., & Rodríguez, C. (2024). Neurodivergent students. A continuum of skills with an emphasis on creativity and executive functions. *Applied Neuropsychology. Child*, 1–13. https://doi.org/10.1080/21622965.2024.2406914

Pawaskar, M., Fridman, M., Grebla, R., & Madhoo, M. (2020). Comparison of Quality of Life, Productivity, Functioning and Self-Esteem in Adults Diagnosed With ADHD and With Symptomatic ADHD. *Journal of Attention Disorders*, *24*(1), 136–144. https://doi.org/10.1177/1087054719841129

Pedersen, A. B., Edvardsen, B. V., Messina, S. M., Volden, M. R., Weyandt, L. L., & Lundervold, A. J. (2024). Self-Esteem in Adults With ADHD Using the Rosenberg Self-Esteem Scale: A Systematic Review. *Journal of Attention Disorders*, *28*(7), 1124–1138. Scopus. https://doi.org/10.1177/10870547241237245

Podsakoff, P. M., MacKenzie, S. B., Lee, J.-Y., & Podsakoff, N. P. (2003). Common method biases in behavioral research: A critical review of the literature and recommended remedies. *Journal of Applied Psychology*, *88*(5), 879–903. https://doi.org/10.1037/0021-9010.88.5.879

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Roen, K., & Duffy, S. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews: A product from the ESRC Methods Programme*. https://doi.org/10.13140/2.1.1018.4643

Price, A., Janssens, A., Newlove-Delgado, T., Eke, H., Paul, M., Sayal, K., Hollis, C., Ani, C., Young, S., Dunn-Morua, S., Asherson, P., Logan, S., & Ford, T. (2020). Mapping UK mental health services for adults with attention-deficit/hyperactivity disorder: National survey with comparison of reporting between three stakeholder groups. *BJPsych Open*, *6*(4), e76. https://doi.org/10.1192/bjo.2020.65

Prosser, B. (2014). *Revisiting medicalization: ADHD and low SES in Australia*. https://doi.org/10.13140/2.1.4742.8804

Prosser, B., & Reid, R. (2013). The DSM-5 changes and ADHD: More than a tweak of terms. *Australian & New Zealand Journal of Psychiatry*, *47*(12), 1196–1197. https://doi.org/10.1177/0004867413509695

Quintero, J., Morales, I., Vera, R., Zuluaga, P., & Fernández, A. (2019). The Impact of Adult ADHD in the Quality of Life Profile. *Journal of Attention Disorders*, *23*(9), 1007–1016. https://doi.org/10.1177/1087054717733046

Ramsay, J. R. (2006). Book Review: Mastering your adult ADHD: A cognitive-behavioral treatment program—Therapist guide; Mastering your adult ADHD: A cognitive-behavioral treatment program—Client workbook. *Journal of Attention Disorders*, *10*(1), 112–113. https://doi.org/10.1177/1087054705286056

Raz, S., & Leykin, D. (2015). Psychological and cortisol reactivity to experimentally induced stress in adults with ADHD. *Psychoneuroendocrinology*, *60*, 7–17. https://doi.org/10.1016/j.psyneuen.2015.05.008

Rogers, C. R. (1959). *A THEORY OF THERAPY, PERSONALITY, AND INTERPERSONAL RELATIONSHIPS, AS DEVELOPED IN THE CLIENT-CENTERED FRAMEWORK*.

Rosqvist, H. B., Hultman, L., Wiklund, S. Ö., Nygren, A., Storm, P., & Sandberg, G. (2023). Intensity and Variable Attention: Counter Narrating ADHD, from ADHD Deficits to ADHD Difference. *The British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcad138

Schei, J., Nøvik, T. S., Thomsen, P. H., Lydersen, S., Indredavik, M. S., & Jozefiak, T. (2018). What Predicts a Good Adolescent to Adult Transition in ADHD? The Role of Self-Reported Resilience. *J. Atten. Disord.*, *22*(6), 547–560. https://doi.org/10.1177/1087054715604362

Schoeman, R., & Voges, T. (2022). Attention-deficit hyperactivity disorder stigma: The silent barrier to care. *The South African Journal of Psychiatry: SAJP: The Journal of the Society of Psychiatrists of South Africa*, *28*, 1865. https://doi.org/10.4102/sajpsychiatry.v28i0.1865

Schrevel, S. J. C., Dedding, C., van Aken, J. A., & Broerse, J. E. W. (2016). 'Do I need to become someone else?' A qualitative exploratory study into the experiences and needs of adults with ADHD. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *19*(1), 39–48. https://doi.org/10.1111/hex.12328

Sedgwick, J. A., Merwood, A., & Asherson, P. (2019). The positive aspects of attention deficit hyperactivity disorder: A qualitative investigation of successful adults with ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, *11*(3), 241–253. https://doi.org/10.1007/s12402-018-0277-6

Simon, V., Czobor, P., Bálint, S., Mészáros, A., & Bitter, I. (2009). Prevalence and correlates of adult attention-deficit hyperactivity disorder: Meta-analysis. *The British Journal of Psychiatry: The Journal of Mental Science*, *194*(3), 204–211. https://doi.org/10.1192/bjp.bp.107.048827

Smith, M. (2012). *Hyperactive: A history of ADHD*. https://consensus.app/papers/hyperactive-a-history-of-adhd-smith/4e656144d4485396b4eeb8ccf4a50b5f/

Smith, M. C. F., Mukherjee, R. A. S., Müller-Sedgwick, U., Hank, D., Carpenter, P., & Adamou, M. (2024). UK adult ADHD services in crisis. *BJPsych Bulletin*, *48*(1), 1–5. https://doi.org/10.1192/bjb.2023.88

Stolte, M., Trindade-Pons, V., Vlaming, P., Jakobi, B., Franke, B., Kroesbergen, E. H., Baas, M., & Hoogman, M. (2022). Characterizing Creative Thinking and Creative Achievements in Relation to Symptoms of Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder. *Frontiers in Psychiatry*, *13*, 909202. https://doi.org/10.3389/fpsyt.2022.909202

Swanepoel, A. (2024). ADHD and ASD are Normal Biological Variations as part of Human Evolution and are not 'Disorders'. *Clinical Neuropsychiatry*, *21*(6), 451–454. https://doi.org/10.36131/cnfioritieditore20240601

Tabachnick, B. G., & Fidell, L. S. (2019). *Using multivariate statistics* (Seventh edition). Pearson.

Taylor, C. L., Said-Metwaly, S., Camarda, A., & Barbot, B. (2023). Gender differences and variability in creative ability: A systematic review and meta-analysis of the greater male variability hypothesis in creativity. *Journal of Personality and Social Psychology*. https://doi.org/10.1037/pspp0000484

Tegtmejer, T. (2018). ADHD in the Interactional Context of Children's Cultures. A sociocultural critique of the individualizing gaze of the diagnosis. *Learning, Culture and Social Interaction*, *17*. https://doi.org/10.1016/j.lcsi.2018.01.001

Timimi, S., & Taylor, E. (2004). ADHD is best understood as a cultural construct. *The British Journal of Psychiatry: The Journal of Mental Science*, *184*, 8–9. https://doi.org/10.1192/bjp.184.1.8

Trott, G.-E. (2006). Attention-deficit/hyperactivity disorder (ADHD) in the course of life. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(1), i21–i25. https://doi.org/10.1007/s00406-006-1003-5

Venkatesan, S., & Tolani, P. (2024). 'Finally making sense': Graphic medicine and ADHD

diagnosis in adulthood. *Medical Humanities*. https://doi.org/10.1136/medhum-2024-

012991

Weibel, S., Bicego, F., Muller, S., Martz, E., Costache, M. E., Kraemer, C., Bertschy, G., Lopez, R.,

& Weiner, L. (2021). Two Facets of Emotion Dysregulation Are Core Symptomatic

Domains in Adult ADHD: Results from the SR-WRAADDS, a Broad Symptom Self-Report

Questionnaire. *Journal of Attention Disorders*, *26*, 767–778.

https://doi.org/10.1177/10870547211027647

Weiner, B. (1985). An attributional theory of achievement motivation and emotion.

Psychological Review, *92*(4), 548–573. https://doi.org/10.1037/0033-295X.92.4.548

Weisner, T. S. (2016). Relationships and social trust in early childhood programs: The

importance of context and mixed methods. In *The culture of child care: Attachment,

peers, and quality in diverse communities* (pp. 107–120). Oxford University Press.

https://doi.org/10.1093/acprof:oso/9780190218089.003.0006

White, H. A., & Shah, P. (2006). Uninhibited imaginations: Creativity in adults with Attention-

Deficit/Hyperactivity Disorder. *Personality and Individual Differences*, *40*(6), 1121–1131.

https://doi.org/10.1016/j.paid.2005.11.007

Willcutt, E. G., Doyle, A. E., Nigg, J. T., Faraone, S. V., & Pennington, B. F. (2005). Validity of the

executive function theory of attention-deficit/hyperactivity disorder: A meta-analytic

review. *Biological Psychiatry*, *57*(11), 1336–1346.

https://doi.org/10.1016/j.biopsych.2005.02.006

Young, Z., Tickle, A., Gillott, A., & Groom, M. (2019, July 1). *Psychological impact of an adult

ADHD diagnosis: 'A blessing and a curse?'. | EBSCOhost*.

https://openurl.ebsco.com/contentitem/gcd:142417705?sid=ebsco:plink:crawler&id=e

bsco:gcd:142417705

Zapata, M. A., & Worrell, F. C. (2023). Disability self-worth and personal meaning relate to

psychosocial functioning among employed U.S. adults with LD and ADHD.

Rehabilitation Psychology, *68*(2), 184–193. https://doi.org/10.1037/rep0000484

APPENDICES

Appendix A: Prospero Review Protocol Registration

NIHR | National Institute for Health and Care Research   **PROSPERO** International prospective register of systematic reviews

Exploring Self-Perceptions in Adults Diagnosed with ADHD: A Systematic Review of Challenges, Stigma, and Emerging Positive Traits

Yonatan Ben-Zion, Keith Sullivan

Citation

Yonatan Ben-Zion, Keith Sullivan. Exploring Self-Perceptions in Adults Diagnosed with ADHD: A Systematic Review of Challenges, Stigma, and Emerging Positive Traits. PROSPERO 2024 Available from https://www.crd.york.ac.uk/PROSPERO/view/CRD42024614293

REVIEW TITLE AND BASIC DETAILS

Review title

Exploring Self-Perceptions in Adults Diagnosed with ADHD: A Systematic Review of Challenges, Stigma, and Emerging Positive Traits

Review objectives

What are the common self-perceptions of adults diagnosed with ADHD?

Keywords

ADHD identity and self-concept, ADHD self-perception, Adult ADHD self-esteem, Attention-Deficit/Hyperactivity Disorder in adults, Creativity and cognitive flexibility in ADHD, Deficit-focused vs. strengths-focused perspectives, Internalised stigma in ADHD, Lived experiences of ADHD, Narrative synthesis in ADHD research, Psychological outcomes in ADHD adults, Qualitative and quantitative synthesis in ADHD, Self-perception in neurodevelopmental disorders, Self-worth in ADHD adults, Strengths and challenges in ADHD

SEARCHING AND SCREENING

Searches

MEDLINE

PubMed

Scopus

The initial search was conducted in February 2024 and repeated in July 2024 to capture any recent publications and ensure the review included the latest findings. During each search round, reference lists of identified articles were reviewed to locate additional studies that may not have been captured by the initial database search. There are no restrictions on publication date. All full text articles must be in English language.

Study design

The review will include empirical studies: quantitative (e.g., descriptive/cross-sectional), qualitative, and mixed-methods designs that address self-perception in adults with ADHD. Excluded will be case studies, opinion pieces, editorials, and studies that focus solely on symptomatology without relevance to self-perception.

ELIGIBILITY CRITERIA

Condition or domain being studied

This review will focus on Attention-Deficit/Hyperactivity Disorder (ADHD) in adults, specifically examining how self-perceptions are shaped in this population. It will explore both challenges, such as internalised stigma and low self-esteem, and positive traits like creativity, which influence personal identity and self-worth in adults with ADHD.

Population

The review will include studies on adults (aged 18 and above) with a formal diagnosis of ADHD. Inclusion criteria specify adults who self-identify as having ADHD or have a confirmed diagnosis, excluding those experiencing unrelated severe psychiatric comorbidities. Studies focusing on children, adolescents, or populations without a formal ADHD diagnosis will be excluded to retain a focus on adult ADHD-specific self-perception.

Intervention(s) or exposure(s)

This review will examine the "exposure" of living with ADHD, with a focus on self-perception in relation to traits and challenges associated with the condition. It will not assess specific interventions, as the review is oriented toward understanding self-perceived strengths, challenges, and identity.

Comparator(s) or control(s)

The review will not include a non-ADHD control or comparison group, as it is intended to synthesise findings specifically within the adult ADHD population. Studies that include comparisons between ADHD and non-ADHD populations will be included only if they add insights into ADHD-specific self-perceptions.

Context

Studies across various real-life settings, including community and clinical environments, will be included if they contribute to understanding self-perception in ADHD. Studies limited to child/

adolescent educational contexts, or those with laboratory-only settings without broader self-assessment, will be excluded.

OUTCOMES TO BE ANALYSED

Main outcomes
The primary outcome will be self-perception in adults with ADHD, measured through self-assessments of self-esteem, internalised stigma, self-worth, and perceived strengths or challenges. These outcomes may be captured through validated self-report measures or qualitative insights on personal identity.

Measures of effect
As the review plans to use a narrative synthesis approach, no specific quantitative measures of effect (such as relative risks or odds ratios) will be calculated. Instead, the review will present descriptive summaries of self-perception trends, such as self-esteem and quality of life scores, to illustrate common themes in ADHD adults.

Additional outcomes
Additional outcomes may include contextual influences, such as societal attitudes, cultural expectations, and the presence of stigma, that could impact ADHD adults' self-concept. These will be noted if available; otherwise, additional outcomes are not a primary focus.

DATA COLLECTION PROCESS

Data extraction (selection and coding)
Studies will be selected for inclusion based on pre-determined eligibility criteria, which align with the population, phenomenon of interest, context, and study design framework. A structured data extraction form will be used to systematically record study details, including participant demographics, focus areas, and findings related to self-perception themes. The data extraction process will ensure consistent categorisation and coding of data, facilitating the organisation of findings into relevant themes. This approach ensures thorough and standardised collection of information, supporting the synthesis of predominant themes across the included studies.

Risk of bias (quality) assessment
To evaluate methodological quality, the review will use the Mixed Methods Appraisal Tool (MMAT), which allows for consistent quality assessment across qualitative, quantitative, and mixed-methods studies. It will focus on areas such as sampling, data collection, and methodological coherence.

PLANNED DATA SYNTHESIS

Strategy for data synthesis
A formal narrative synthesis will be conducted to analyse and interpret qualitative data from the

included studies. The synthesis will focus on identifying shared themes related to self-perception in adults with ADHD, including low self-esteem, stigma, and perceived strengths.

Grouping Studies for Synthesis:

Studies will be grouped based on:

Participant demographics, such as age and gender, to examine variations in self-perception across different groups.

Context of the studies, including clinical or community settings, to explore how environment influences findings.

The focus of the findings, such as challenges (e.g., stigma, self-esteem) or strengths (e.g., creativity, resilience).

Investigating Heterogeneity:

Heterogeneity will be addressed by documenting:

Differences in study populations (e.g., variations in age, gender, or cultural backgrounds).

Study contexts, such as healthcare or educational settings, and how they might influence reported findings.

Variations in the conceptualisation of self-perception themes across studies (e.g., strengths versus deficit-based approaches).

Certainty of Evidence:

The quality and relevance of studies were critically appraised during the selection process, focusing on the alignment of findings with the review's aim. Consistency across studies will be highlighted to ensure confidence in shared themes, while divergent findings will be noted and explored in the synthesis.

Presentation of Data:

Findings will be presented narratively, supported by:

A structured discussion of overarching themes and subthemes identified across the studies.

If relevant, direct participant quotes from the studies to illustrate key themes and provide contextual depth.

Tables summarising study characteristics (e.g., demographics, context, and focus) to provide a clear overview of the included studies.

Interpretation of Results:

The synthesis will interpret how adults with ADHD perceive themselves, focusing on how themes such as stigma and strengths interact. Divergences in findings will be contextualised based on study populations and settings, with implications for future research and practice discussed.

Analysis of subgroups or subsets

Planned subgroup analysis will likely be limited, as the primary focus is on synthesising self-perception across the adult ADHD population as a whole. However, any differences by demographic or cultural factors will be noted narratively if these data are available.

REVIEW AFFILIATION, FUNDING AND PEER REVIEW

Review team members

- Mr Yonatan Ben-Zion, University of Hertfordshire
- Dr Keith Sullivan, University of Hertfordshire

Review affiliation
University of Hertfordshire

Funding source
Univeristy of Hertfordshire

Named contact
Yonatan Ben-Zion.
y.ben-zion@herts.ac.uk

TIMELINE OF THE REVIEW

Review timeline
Start date: 02 September 2024. End date: 03 February 2025

Date of first submission to PROSPERO
26 November 2024

Date of registration in PROSPERO
11 December 2024

CURRENT REVIEW STAGE

Publication of review results
The intention is to publish the review once completed. The review will be published in English

Stage of the review at this submission

Review stage	Started	Completed
Pilot work	✓	
Formal searching/study identification	✓	
Screening search results against inclusion criteria	✓	
Data extraction or receipt of IP		
Risk of bias/quality assessment		
Data synthesis		

Review status
The review is currently planned or ongoing.

ADDITIONAL INFORMATION

PROSPERO version history

- Version 1.0 published on 11 Dec 2024

Review conflict of interest
None known

Country
England

Medical Subject Headings
Adult; Attention Deficit Disorder with Hyperactivity; Humans; Self Concept; Social Stigma

Disclaimer
The content of this record displays the information provided by the review team. PROSPERO does not peer review registration records or endorse their content.

PROSPERO accepts and posts the information provided in good faith; responsibility for record content rests with the review team. The owner of this record has affirmed that the information provided is truthful and that they understand that deliberate provision of inaccurate information may be construed as scientific misconduct.

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Any enquiries about the record should be referred to the named review contact

Appendix B: Quality Assessment tools

CASP Quality Appraisal Table

Study (Author, Year)	Fleischmann & Fleischmann, 2012	Schrevel et al., 2016	Mahdi et al., 2017	Godfrey-Harris & Shaw, 2023	Sedgwick et al., 2019	Schei et al., 2015
Clear Aims?	✓	✓	✓	✓	✓	✓
Qualitative Method Appropriate?	✓	✓	✓	✓	✓	✓
Research Design Appropriate?	✓	✓	✓	✓	✓	✓
Recruitment Strategy Appropriate?	✓	✓	✓	✓	✓	✓
Data Collection Addresses Issue?	✓	✓	✓	✓	✓	✓
Researcher-Participant Relationship Considered?	✗	✗	✗	✓	✗	✗
Ethical Issues Considered?	✓	✓	✓	✓	✓	✓
Data Analysis Rigorous?	✓	✓	✓	✓	✓	✓
Clear Findings?	✓	✓	✓	✓	✓	✓
Valuable Research?	✓	✓	✓	✓	✓	✓
Total Score	8	8	8	10	8	8
Quality Rating	Good	Good	Good	Good	Good	Good

JBI Cohort Studies Quality Appraisal Table (For Hechtman et al., 1980)

Study (author, year)	Hechtman et al., 1980
Were the two groups similar and recruited from the same population?	✓
Were the exposures measured similarly to assign people to both exposed and unexposed groups?	✓
Was the exposure measured in a valid and reliable way?	✓
Were confounding factors identified and strategies to deal with them stated?	✗
Were participants free of the outcome at the start of the study (or at the moment of exposure)?	✓
Were the outcomes measured in a valid and reliable way?	✓
Was the follow-up time reported and sufficient to be long enough for outcomes to occur?	✓
Was follow-up complete, and if not, were differences between groups in terms of follow-up adequately described and analysed?	✓
Were the strategies to address incomplete follow-up utilised?	✓
Total score	9
Quality rating	Good

JBI Cross-Sectional Studies Quality Appraisal Table (For Newark et al., 2016 & Pawaskar et al., 2020)

Study (Author, Year)	Newark et al., 2016	Pawaskar et al., 2020
Were the criteria for inclusion in the sample clearly defined?	✓	✓
Were the study subjects and the setting described in detail?	✓	✓
Was the exposure measured in a valid and reliable way?	✓	✓
Were objective, standard criteria used for measurement of the condition?	✓	✓
Were confounding factors identified?	✓	✓
Were strategies to deal with confounding factors stated?	✓	✓
Were the outcomes measured in a valid and reliable way?	✓	✓
Was appropriate statistical analysis used?	✓	✓
Was the response rate adequate, and if not, was the low response rate managed appropriately?	-	-
Total Score	8	8
Quality Rating	Good	Good

JBI Case-Control Studies Quality Appraisal Table (For Mörstedt et al., 2015)

Study (Author, Year)	Mörstedt et al., 2015
Were the groups comparable other than the presence of disease?	✓
Were cases and controls appropriately matched?	✓
Were the same criteria used for identification of cases and controls?	✓
Was the exposure measured in a standard, valid, and reliable way?	✓
Was exposure assessed in the same way for cases and controls?	✓
Were confounding factors identified?	✓
Were strategies to deal with confounding factors stated?	-
Was the time period between exposure and outcome appropriate?	✓
Was appropriate statistical analysis used?	✓
Total Score	8
Quality Rating	Good

Appendix C: Ethical Approval

To: Mr Yonatan Ben-Zion

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Beyond Deficits: A Strength-Based Exploration of ADHD

Your UH protocol number is: **0469 2024 Dec HSET**
The Protocol Number issued from the online system replaces any previously issued protocol numbers and should be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 28/03/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

Appendix D: Participant Information Sheet

Title of study
Beyond Deficits: A Strength-Based Exploration of ADHD

Introduction
You are invited to consider taking part in a research study. I am a Trainee Clinical Psychologist at the University of Hertfordshire and I am completing this study as part of my Doctorate in Clinical Psychology (DClinPsy).

Before you decide whether to participate, it is important that you read this Information Sheet to understand the aims of the study, who is eligible to take part, and what it will involve. Please take the time to read the following information carefully, and there are contact details provided at the end if you wish to get in touch with the Primary Researcher for further information.
Thank you for reading this information sheet.

What is the purpose of this study?
This study aims to examine the positive aspects of ADHD, focusing on how individuals with ADHD recognise and value their unique strengths. It seeks to understand the impact of these strengths on self-perception and well-being, contributing to a more comprehensive and positive view of ADHD. The research will provide insights that could inform support strategies, emphasising the positive contributions of individuals with ADHD.

This study aims to explore an alternative understanding of how those diagnosed with ADHD identify with possible strengths resulting from the condition, rather than focusing solely on the 'problems'. It hopes to identify and inform new ways of understanding the experiences of those with ADHD, and move towards recognising some of the positive qualities inherent in the experience. This is not to discount the many challenges and difficulties that arise with the condition, but open up a new area of focus where we consider the strengths.

Who can participate?
We are inviting individuals who meet the following criteria to participate in the study:
1) Adult with a formal diagnosis of ADHD from a qualified practitioner e.g Specialist Psychiatrist or Specialist ADHD Nurse
2) Living in the UK
3) 18+ years old

If you do not meet the criteria outlined above, you are not eligible to participate in this study. Please note: if you identify with ADHD, though without a diagnosis, you are also not eligible to participate.

What will taking part involve?
If you would like to participate in this study, you will first be asked to confirm that you consent at the end of this Information Sheet. Participation will involve completing an online questionnaire via the platform Qualtrics, about your identification with character strengths and virtues. You will also be asked to complete two other questionnaires; a brief ADHD screen and a quality of life measure. The whole questionnaire will take approximately 20 minutes to complete. If you wish and/or need to take breaks, you will be able to do so by saving your progress at the bottom of each page. It is important that you try to complete it all if you can.
After you have submitted your responses, you will have the option to enter a prize draw using your email address to win one of three £50 Love2Shop voucher.

Do I have to take part?
No, your involvement in the study is entirely voluntary. Agreeing to join the study also does not mean you have to complete it - you are free to withdraw at any time before the electronic submission of your questionnaire by simply closing the browser window. Due to the anonymisation process, it will not be possible to remove your responses following submission of the questionnaire. Please note that if you decide to withdraw or not complete the study, you will not be eligible for the prize draw.

What are the possible benefits of taking part?
Participation in this study will help to develop understanding about, and give voice to, how individuals with ADHD identify with positive character attributes. It will also contribute to the growing body of literature to support our understanding of how these identified strengths might be used in the process of assessment and therapy. In addition, following participation, you will have the option to enter a prize draw to win one of three £50 Love2Shop voucher.

What are the possible risks of taking part?

STRENGTH-BASED CHARACTERISTICS IN ADULTS WITH ADHD

Whilst the research has been designed in a way to minimise harm, it is possible that you may feel emotional reflecting on how strengths can be viewed within ADHD. If this does happen, we encourage you to take care of yourself, which may include taking a break from completing the questionnaire and returning to it when you feel able to. If you feel it would be helpful to access support after participating, details will be provided upon submitting the questionnaire.

Will my taking part in this study be confidential?
Yes, the questionnaire is confidential and you will not be asked to share information such as your name or address. You will be asked about your age, gender, ethnicity, and occupational status. There is an option to be included in a prize draw upon completion by providing your email address, but this will be kept entirely separately and is not a requirement of participation.

What will happen to the data collected in this study?
Data collected in this study will be processed and kept in accordance with the Data Protection Act (2018) and the BPS's ethical guidelines for internet mediated research (2021). Any email addresses provided by participants for the prize draw will be stored separately to their questionnaire data and in a password protected file, and will be deleted following the prize draw. The anonymised data will be stored for 5 years after completion of the study in accordance with the University of Hertfordshire's policies, and destroyed thereafter.

Will the data be required for use in further studies?
The anonymised data is not intended to be used for further studies and will be destroyed after the research has concluded.

Who has reviewed and approved this study?
This study has been reviewed and approved by the University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee with Delegated Authority. The University of Hertfordshire's protocol number is: [INSERT HERE].

Who is in the research team and who can I contact if I have any questions?
If you wish to obtain further information about this study, please contact the Primary Researcher, Yoni Ben-Zion, using the contact details below:

Primary Researcher: Yoni Ben-Zion
Trainee Clinical Psychologist
Doctorate in Clinical Psychology Programme, University of Hertfordshire
Yb22aai@herts.ac.uk

Principal Supervisor: Dr Keith Sullivan
Senior Research Fellow
Doctorate in Clinical Psychology Programme, University of Hertfordshire
k.sullivan3@herts.ac.uk

Secondary Supervisor: Dr Antonia Dittner
Principal Psychologist
National Adult Autism and ADHD Psychology Service (NAAAPS), South London & Maudsley NHS
Antonia.Dittner@slam.nhs.uk

If you have concerns or complaints about any aspect of this study, you can write to the university's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Hertfordshire
AL10 9AB

Thank you very much for reading this information sheet and considering taking part in this study.

Appendix E: Consent Form

Having read the research study's Information Sheet, do you consent to participating? **[Closed response options]**

1. I confirm that I have read and understood the Information Sheet - YES/NO

2. I understand that I am free to withdraw at any point prior to electronic submission (at which point I will not be able to due to the anonymisation process) - YES/NO

3. I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used - YES/NO

4. I voluntarily agree to participate in this research study - YES/NO

Appendix F: Poster for Recruitment

RESEARCH PARTICIPANTS NEEDED!

DO YOU IDENTIFY WITH ANY POSITIVE QUALITIES OF ADHD?

We're exploring how much you connect with the positive traits linked to ADHD. Our goal is to find methods that help us focus not just on the challenges of ADHD but on its strengths too. By doing so, we aim to improve how we understand, diagnose, and support those with the condition in a more positive light.

Participants must be 18+

WHAT TO EXPECT

An anonymous online questionnaire divided into three sections:

• A short survey about ADHD

• A questionnaire exploring your quality of life

• A survey aimed at exploring potential positive aspects of living with ADHD.

The questionnaire will last up to 15 minutes

PRIZE DRAW

You will have the option to enter a prize draw at the end of the survey

CONFIDENTIAL

The questionnaire is confidential, and we won't ask for your name or address. We'll ask about your age, gender, ethnicity, and job. You can choose to enter a prize draw by giving your email after finishing, but it's optional and kept separate from your answers.

(see questionnaire for more info)

Ethics Protocol No: 0469 2024 Dec HSET

INTERESTED?

To take part, click on the link below or scan the QR Code:

ANY QUESTIONS? Please e-mail the Primary Researcher, Yoni Ben-Zion (Trainee Clinical Psychologist, University Of Hertfordshire): yb22aai@herts.ac.uk

University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority (HSET ECDA), University of Hertfordshire UH Ethics Committee

Appendix G: Raffle prize draw information

Excel procedure from original full list of 211 participants:

Steps for Cleaning Raffle Entries with Find & Select

1. Opened the Excel file containing participant emails submitted for the raffle draw.
2. Selected the column containing participant contact information (e.g., email addresses).
3. Clicked on the "Home" tab, then selected "Find & Select" > "Go To Special…".
4. In the pop-up box, chose "Blanks" and clicked OK.
5. Excel highlighted all blank cells in the selected column.
6. With blank cells selected, right-clicked on any one of them and chose "Delete".
7. In the delete options, selected "Entire Row" to ensure the whole row was removed.
8. Saved the cleaned dataset, which now only included complete entries.

This process ensures that any incomplete submissions (e.g., missing email addresses) are excluded from the raffle draw. Removing blank rows prevents invalid or uncontactable entries from being accidentally selected, ensuring fairness and accuracy in the prize allocation.

Remainder involved in raffle: n=171

Random number generator website: https://www.random.org/

True Random Number Generator

Min: 1
Max: 171
Generate
Result:

76
Min: 1, Max: 171
2025-05-25 10:45:31 UTC

Powered by RANDOM.ORG
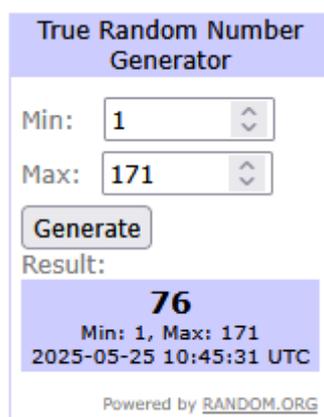
Appendix H: Adult Strengths Identification Questionnaire

ADULT STRENGTH IDENTIFICATION QUESTIONNAIRE (ASIQ)

This questionnaire uses a Likert scale (1 = Strongly Disagree, 5 = Strongly Agree) for responses.

1. I frequently think of ideas that others might find unusual or unexpected.
2. I often find it difficult to come up with different ways of seeing a situation.
3. If my first idea doesn't work, I tend to struggle with trying a different approach.
4. When I'm interested in something, I can get so absorbed that I lose track of time or forget to take breaks.
5. It's easy for me to disengage from a task, even when I'm deeply involved in it.
6. When something fully captures my attention, I tend to ignore distractions around me.
7. I often feel a high level of energy and excitement about starting new projects.
8. I rarely feel the need to be active or moving, even when I'm excited or deep in thought.
9. When a task feels challenging, I tend to feel less eager to tackle it.
10. I often feel a strong sense of empathy when I see others struggling.
11. In social settings, I usually feel disengaged and uninterested in connecting with others.
12. I enjoy using humour spontaneously to connect with people.
13. When I face a setback, I tend to lose motivation to keep trying.
14. In difficult situations, I often feel a sense of hope about finding a solution.
15. If my plans don't work out, I find it hard to adapt and try a new approach.
16. I actively seek out new and stimulating experiences that others might find overwhelming.
17. I prefer familiar situations to unfamiliar ones, which usually make me uneasy.
18. I enjoy exploring new topics, even if they're unconventional or challenging.
19. I am able to see situations from multiple perspectives without much effort.
20. I often struggle to adjust when plans change unexpectedly.
21. If my first approach to a problem doesn't work, I find it challenging to try a different strategy.
22. I often notice patterns and connections that others might overlook.
23. I rarely focus on the bigger picture when analysing complex problems.
24. When faced with complex information, I find it hard to break it down into simpler components.

Appendix I: Adult ADHD Self-Report Scale (ASRS-v.1.1) Symptom Checklist

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

STRENGTH-BASED CHARACTERISTICS IN ADULTS WITH ADHD

Appendix J: Qualtrics Demographics Survey

▾ About you

Q1 ✱

▾ 🔵 Skip to

End of Survey if Age Is Less Than 18

What is your age?

0   100

Age 🔵 0

Q2 ✱

What gender do you identify as?

○ Male
○ Female
○ Non-binary / third gender
○ Other (please enter)
[   ]

Q3

How would you describe your ethnicity?

○ Asian or Asian British
○ Black, Black British, Caribbean or African
○ Mixed or Multiple ethnic groups
○ White
○ Other ethnic group

Q4 | Note: if you are currently in education, please choose the result at the end of your qualification. ✱

What is your highest level of education?

○ None
○ GCSE or Foundation diploma
○ A levels, BTEC, International Baccalaureate, NVQ3
○ Higher national certificate, NVQ4
○ Foundation degree, Higher national diploma, Degree apprenticeship
○ Bachelors degree - BA or BSc
○ Masters degree
○ Doctorate, PhD
○ Other
[   ]

.... Page Break ....

☐ Q7 ✱

What is your occupational status?

☐ Unemployed
☐ Student
☐ Employed Full-time
☐ Employed Part-time
☐ Self-employed
☐ Retired

☐ ✱

What city do you live in?

[   ]

$*$

What year did you receive your diagnosis?

$*$

What treatment, if any, have you used to support the condition?

- [ ] None
- [ ] Medication
- [ ] Behavioural therapy
- [ ] Counselling/psychotherapy
- [ ] Not currently receiving treatment
- [ ] Prefer not to say

$*$

Skip to

End of Survey if Yes Is Selected

Have you recieved a diagnosis of any of the following: Generalised Anxiety Disorder, PTSD, Psychosis, Suicidality, Bipolar Disorder or Substance Misuse?

- ( ) Yes
- ( ) No

$*$

Do you believe there are any positives or strengths to having ADHD?

- ( ) Yes
- ( ) No
- ( ) Maybe

Appendix J: Participant De-brief and Signposting

Signposting to further support

Thank you very much for participating and making this study possible.
Since the survey is anonymous, we are unable to remove your data once you have submitted. Please contact the main researcher or supervisor if you have any further questions:

Researcher: Yoni Ben-Zion
Yb22aai@herts.ac.uk

Supervisor Dr Keith Sullivan
k.sullivan3@herts.ac.uk

If you have found any of the information distressing, or you are seeking further support, we have enclosed below details of services that are able to offer additional support, if needed.

Services offering support
There are a number of local sources of support which may already be familiar to you if you find that taking part in this study and talking about your experiences has left you distressed. Whilst this is quite understandable and normal, if these feelings persist you may find the following services useful:

The Brain Charity
www.thebraincharity.org.uk/
Provides practical help on all aspects of living with attention deficit disorder, emotional support such as counselling, phone befriending and group therapy and social activities to people with attention deficit disorder from all over the UK.

ADHDadultUK
https://www.adhdadult.uk/
ADHDadultUK provides peer-led support and coaching to adults with ADHD to support multiple aspects of living with ADHD. ADHDAware www.adhdaware.org.uk ADHDAware provides support in the forms of drop-ins, group discussions, and for partners of adults with ADHD. These are often hosted online Zoom.
Alternatively, your GP may be able to refer you to more specialised local support services

Appendix K: Statistical Analysis Outputs

Preliminary EFA Factor Matrix (original 24 questions)

Factor Matrix[a]

	1	2	3	4	5	6	7
V1	.461	.544					
V2	.670						
V3	-.649				.430		
V4		.367					
V5			.543				.331
V6		.343					
V7	.409						
V8	-.351		-.305	.341			
V9	.425	-.323					
V10							
V11	-.407						
V12							
V13	-.438	.330					
V14	.567						.441
V15	-.559	.340					
V16	.370			.395			
V17	.511						
V18	.560	.301					
V19	.623						
V20	-.396	.334		-.318			
V21	-.588				.363		
V22	.392	.386					
V23	-.396						
V24	-.346	.420					

Extraction Method: Principal Axis Factoring.

a. Attempted to extract 7 factors. More than 25 iterations required. (Convergence=.002). Extraction was terminated.

Reliability testing for 2-factors

Case Processing Summary

		N	%
Cases	Valid	167	100.0
	Excluded[a]	0	.0
	Total	167	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.703	7

Item Statistics

	Mean	Std. Deviation	N
V1	4.31	.758	167
V2	3.56	1.128	167
V4	4.69	.557	167
V6	4.13	.985	167
V14	3.50	1.097	167
V19	4.04	.963	167
V22	4.40	.776	167

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
V1	24.32	11.483	.522	.648
V2	25.07	10.050	.478	.652
V4	23.93	13.501	.228	.707
V6	24.49	12.083	.247	.714
V14	25.12	10.504	.427	.668
V19	24.59	10.087	.610	.613
V22	24.23	11.864	.426	.668

Case Processing Summary

		N	%
Cases	Valid	167	100.0
	Excluded[a]	0	.0
	Total	167	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.715	5

Item Statistics

	Mean	Std. Deviation	N
V3	2.99	.994	167
V13	3.65	1.036	167
V15	3.25	1.089	167
V20	3.69	1.079	167
V24	3.54	1.191	167

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
V3	14.13	9.737	.467	.670
V13	13.47	9.552	.468	.669
V15	13.87	8.549	.610	.609
V20	13.42	9.630	.421	.687
V24	13.57	9.222	.412	.695

ANOVA and t-tests

Factor loadings on Gender

T-Test

Group Statistics

	Gender	N	Mean	Std. Deviation	Std. Error Mean
Factor1_Adaptability	Male	35	3.4229	.68560	.11589
	Female	124	3.4323	.76780	.06895
Factor2_CreativeThinking	Male	35	3.8286	.51601	.08722
	Female	124	4.1406	.54314	.04878

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Factor1_Adaptability	Equal variances assumed	.602	.439	-.065	157	.948	-.00940	.14370	-.29324	.27443
	Equal variances not assumed			-.070	60.246	.945	-.00940	.13485	-.27912	.26031
Factor2_CreativeThinking	Equal variances assumed	.258	.612	-3.033	157	.003	-.31198	.10286	-.51514	-.10882
	Equal variances not assumed			-3.122	57.048	.003	-.31198	.09993	-.51209	-.11187

Factor loadings on educational attainment

T-Test

Group Statistics

	Education	N	Mean	Std. Deviation	Std. Error Mean
Factor1_Adaptability	Below Undergraduate	62	3.7000	.63427	.08055
	Above Undergraduate	105	3.2590	.74881	.07308
Factor2_CreativeThinking	Below Undergraduate	62	3.9862	.62976	.07998
	Above Undergraduate	105	4.1497	.48743	.04757

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Factor1_Adaptability	Equal variances assumed	2.184	.141	3.885	165	.000	.44095	.11350	.21686	.66504
	Equal variances not assumed			4.054	145.084	.000	.44095	.10876	.22599	.65591
Factor2_CreativeThinking	Equal variances assumed	3.877	.051	-1.875	165	.063	-.16348	.08719	-.33564	.00868
	Equal variances not assumed			-1.757	104.146	.082	-.16348	.09306	-.34802	.02105

Factor loadings on Treatment type

T-Test

Group Statistics

	Treatment	N	Mean	Std. Deviation	Std. Error Mean
Factor1_Adaptability	No Treatment	46	3.4130	.75590	.11145
	Treatment	117	3.4171	.74119	.06852
Factor2_CreativeThinking	No Treatment	46	4.0404	.53339	.07864
	Treatment	117	4.0940	.55587	.05139

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Factor1_Adaptability	Equal variances assumed	.108	.742	-.031	161	.975	-.00405	.12971	-.26020	.25210
	Equal variances not assumed			-.031	80.963	.975	-.00405	.13083	-.26436	.25626
Factor2_CreativeThinking	Equal variances assumed	.496	.482	-.561	161	.576	-.05364	.09566	-.24256	.13527
	Equal variances not assumed			-.571	85.582	.569	-.05364	.09395	-.24042	.13313

One-way ANOVA for socioeconomic deprivation loadings on 2 factors

Descriptives

		N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
						Lower Bound	Upper Bound		
Factor1_Adaptability	Low Deprivation	45	3.4133	.75124	.11199	3.1876	3.6390	1.60	5.00
	Medium Deprivation	42	3.3857	.72501	.11187	3.1598	3.6116	1.60	4.60
	High Deprivation	43	3.4140	.82853	.12635	3.1590	3.6689	1.20	4.80
	Total	130	3.4046	.76370	.06698	3.2721	3.5371	1.20	5.00
Factor2_CreativeThinking	Low Deprivation	45	4.1841	.55129	.08218	4.0185	4.3498	2.86	5.00
	Medium Deprivation	42	3.9796	.66076	.10196	3.7737	4.1855	2.43	5.00
	High Deprivation	43	4.0166	.47196	.07197	3.8714	4.1619	3.00	5.00
	Total	130	4.0626	.56838	.04985	3.9640	4.1613	2.43	5.00

Test of Homogeneity of Variances

		Levene Statistic	df1	df2	Sig.
Factor1_Adaptability	Based on Mean	.398	2	127	.672
	Based on Median	.326	2	127	.723
	Based on Median and with adjusted df	.326	2	122.701	.723
	Based on trimmed mean	.393	2	127	.676
Factor2_CreativeThinking	Based on Mean	1.608	2	127	.204
	Based on Median	1.419	2	127	.246
	Based on Median and with adjusted df	1.419	2	113.849	.246
	Based on trimmed mean	1.454	2	127	.237

ANOVA

		Sum of Squares	df	Mean Square	F	Sig.
Factor1_Adaptability	Between Groups	.022	2	.011	.019	.981
	Within Groups	75.215	127	.592		
	Total	75.237	129			
Factor2_CreativeThinking	Between Groups	1.045	2	.522	1.633	.199
	Within Groups	40.629	127	.320		
	Total	41.674	129			

Post Hoc Tests

Multiple Comparisons

Dependent Variable		(I) IMD_Score (Binned)	(J) IMD_Score (Binned)	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Factor1_Adaptability	Tukey HSD	Low Deprivation	Medium Deprivation	.02762	.16511	.985	-.3639	.4192
			High Deprivation	-.00062	.16412	1.000	-.3898	.3886
		Medium Deprivation	Low Deprivation	-.02762	.16511	.985	-.4192	.3639
			High Deprivation	-.02824	.16696	.984	-.4242	.3677
		High Deprivation	Low Deprivation	.00062	.16412	1.000	-.3886	.3898
			Medium Deprivation	.02824	.16696	.984	-.3677	.4242
	Bonferroni	Low Deprivation	Medium Deprivation	.02762	.16511	1.000	-.3730	.4282
			High Deprivation	-.00062	.16412	1.000	-.3988	.3975
		Medium Deprivation	Low Deprivation	-.02762	.16511	1.000	-.4282	.3730
			High Deprivation	-.02824	.16696	1.000	-.4333	.3768
		High Deprivation	Low Deprivation	.00062	.16412	1.000	-.3975	.3988
			Medium Deprivation	.02824	.16696	1.000	-.3768	.4333
Factor2_CreativeThinking	Tukey HSD	Low Deprivation	Medium Deprivation	.20454	.12135	.215	-.0832	.4923
			High Deprivation	.16752	.12062	.350	-.1185	.4536
		Medium Deprivation	Low Deprivation	-.20454	.12135	.215	-.4923	.0832
			High Deprivation	-.03702	.12271	.951	-.3280	.2540
		High Deprivation	Low Deprivation	-.16752	.12062	.350	-.4536	.1185
			Medium Deprivation	.03702	.12271	.951	-.2540	.3280
	Bonferroni	Low Deprivation	Medium Deprivation	.20454	.12135	.283	-.0899	.4989
			High Deprivation	.16752	.12062	.502	-.1251	.4601
		Medium Deprivation	Low Deprivation	-.20454	.12135	.283	-.4989	.0899
			High Deprivation	-.03702	.12271	1.000	-.3347	.2607
		High Deprivation	Low Deprivation	-.16752	.12062	.502	-.4601	.1251
			Medium Deprivation	.03702	.12271	1.000	-.2607	.3347

Homogeneous Subsets

Factor1_Adaptability

	IMD_Score (Binned)	N	Subset for alpha = 0.05
			1
Tukey HSD[a,b]	Medium Deprivation	42	3.3857
	Low Deprivation	45	3.4133
	High Deprivation	43	3.4140
	Sig.		.984

Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 43.298.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

Factor2_CreativeThinking

	IMD_Score (Binned)	N	Subset for alpha = 0.05
			1
Tukey HSD[a,b]	Medium Deprivation	42	3.9796
	High Deprivation	43	4.0166
	Low Deprivation	45	4.1841
	Sig.		.216

Ordinal Regression

Factor 1

Case Processing Summary

		N	Marginal Percentage
Factor1_Adaptability	1.20	1	0.8%
	1.60	2	1.7%
	1.80	1	0.8%
	2.00	2	1.7%
	2.20	2	1.7%
	2.40	8	6.6%
	2.60	7	5.8%
	2.80	9	7.4%
	3.00	9	7.4%
	3.20	10	8.3%
	3.40	8	6.6%
	3.60	13	10.7%
	3.80	14	11.6%
	4.00	12	9.9%
	4.20	9	7.4%
	4.40	5	4.1%
	4.60	7	5.8%
	4.80	1	0.8%
	5.00	1	0.8%
Gender	Male	26	21.5%
	Female	92	76.0%
	Non-binary / third gender	1	0.8%
	Prefer not to say	2	1.7%
Education	Below Undergraduate	48	39.7%
	Above Undergraduate	73	60.3%
Occupational_Status	Unemployed	14	11.6%
	Student	8	6.6%
	Employed full-time	70	57.9%
	Employed part-time	11	9.1%
	Self-employed	14	11.6%
	Retired	4	3.3%
IMD_Score (Binned)	Low Deprivation	41	33.9%
	Medium Deprivation	39	32.2%
	High Deprivation	41	33.9%
Treatment	No Treatment	32	26.4%
	Treatment	88	72.7%
	6	1	0.8%
Valid		121	100.0%
Missing		46	
Total		167	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	514.966			
Final	496.407	18.560	13	.137

Link function: Logit.

Goodness-of-Fit

	Chi-Square	df	Sig.
Pearson	1105.486	1031	.053
Deviance	412.162	1031	1.000

Link function: Logit.

Parameter Estimates

		Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Threshold	[Factor1_Adaptability = 1.20]	-3.443	2.578	1.783	1	.182	-8.496	1.611
	[Factor1_Adaptability = 1.60]	-2.314	2.443	.897	1	.344	-7.102	2.474
	[Factor1_Adaptability = 1.80]	-2.006	2.426	.683	1	.408	-6.760	2.749
	[Factor1_Adaptability = 2.00]	-1.564	2.410	.421	1	.516	-6.287	3.159
	[Factor1_Adaptability = 2.20]	-1.244	2.402	.268	1	.605	-5.952	3.465
	[Factor1_Adaptability = 2.40]	-.426	2.395	.032	1	.859	-5.120	4.267
	[Factor1_Adaptability = 2.60]	.042	2.395	.000	1	.986	-4.652	4.736
	[Factor1_Adaptability = 2.80]	.513	2.397	.046	1	.831	-4.185	5.210
	[Factor1_Adaptability = 3.00]	.911	2.399	.144	1	.704	-3.791	5.612
	[Factor1_Adaptability = 3.20]	1.299	2.401	.293	1	.588	-3.407	6.005
	[Factor1_Adaptability = 3.40]	1.591	2.402	.439	1	.508	-3.118	6.300
	[Factor1_Adaptability = 3.60]	2.069	2.405	.740	1	.390	-2.644	6.782
	[Factor1_Adaptability = 3.80]	2.633	2.407	1.197	1	.274	-2.084	7.351
	[Factor1_Adaptability = 4.00]	3.224	2.409	1.790	1	.181	-1.498	7.946
	[Factor1_Adaptability = 4.20]	3.834	2.414	2.522	1	.112	-.898	8.565
	[Factor1_Adaptability = 4.40]	4.340	2.421	3.213	1	.073	-.406	9.086
	[Factor1_Adaptability = 4.60]	5.936	2.498	5.645	1	.018	1.039	10.833
	[Factor1_Adaptability = 4.80]	6.640	2.596	6.544	1	.011	1.553	11.727
Location	[Gender=1]	.828	1.329	.389	1	.533	-1.775	3.432
	[Gender=2]	1.221	1.281	.909	1	.340	-1.290	3.732
	[Gender=3]	.501	2.260	.049	1	.825	-3.928	4.930
	[Gender=4]	0ᵃ	.	.	0	.	.	.
	[Education=0]	.986	.361	7.463	1	.006	.278	1.693
	[Education=1]	0ᵃ	.	.	0	.	.	.
	[Occupational_Status=1]	1.263	1.046	1.459	1	.227	-.786	3.313
	[Occupational_Status=2]	.909	1.100	.683	1	.409	-1.246	3.064
	[Occupational_Status=3]	.918	.931	.973	1	.324	-.906	2.743
	[Occupational_Status=4]	-.209	1.056	.039	1	.843	-2.278	1.861
	[Occupational_Status=5]	.803	1.027	.611	1	.435	-1.211	2.816
	[Occupational_Status=6]	0ᵃ	.	.	0	.	.	.
	[IMD_Group=1]	-.196	.394	.248	1	.618	-.968	.576
	[IMD_Group=2]	-.118	.400	.087	1	.768	-.901	.666
	[IMD_Group=3]	0ᵃ	.	.	0	.	.	.
	[Treatment=0]	-.153	1.814	.007	1	.933	-3.709	3.403
	[Treatment=1]	-.726	1.789	.165	1	.685	-4.231	2.780
	[Treatment=6]	0ᵃ	.	.	0	.	.	.

Link function: Logit.

a. This parameter is set to zero because it is redundant.

STRENGTH-BASED CHARACTERISTICS IN ADULTS WITH ADHD

Cell Information

Frequency

Gender	Education	Occupational_Status	IMD_Score (Binned)	Treatment		Factor1_Adaptability 1.20	1.60	1.80	2.00	2.20	2.40	2.60	2.80	3.00	3.20	3.40	3.60	3.80	4.00	4.20	4.40	4.60	4.80	5.00
Male	Below Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.004	.008	.004	.008	.009	.038	.038	.054	.061	.075	.064	.116	.139	.127	.098	.056	.079	.011	.011
					Pearson Residual	-.061	-.088	-.064	-.092	-.093	-.199	-.197	-.240	-.256	-.284	-.262	2.762	-.402	-.381	-.330	-.244	-.292	-.106	-.106
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.003	.006	.003	.007	.007	.032	.032	.047	.054	.067	.060	.111	.140	.135	.110	.065	.093	.013	.014
					Pearson Residual	-.055	-.080	-.058	-.083	-.085	-.181	-.181	-.222	-.239	-.269	-.252	-.354	-.404	2.850	-.331	-.263	-.321	-.117	-.117
		Student	Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.005	.010	.005	.011	.011	.049	.047	.066	.072	.084	.070	.119	.133	.113	.083	.045	.062	.009	.008
					Pearson Residual	-.070	-.101	-.073	-.105	-.106	-.226	-.221	-.265	3.592	-.302	-.273	-.367	-.391	-.357	-.300	-.218	-.256	-.093	-.093
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.004	.009	.005	.010	.010	.044	.043	.061	.067	.080	.068	.118	.136	.119	.089	.050	.069	.010	.010
					Pearson Residual	-.066	-.095	-.069	-.099	-.101	-.214	-.211	-.254	3.717	-.295	-.269	-.366	-.397	-.368	-.313	-.229	-.271	-.098	-.098
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	1	0	1	0	0	0	0	0
					Expected	.016	.032	.017	.035	.036	.154	.148	.206	.224	.257	.211	.357	.392	.328	.237	.129	.174	.024	.024
					Pearson Residual	-.125	-.180	-.130	-.187	-.190	-.404	-.394	1.810	-.491	-.531	-.477	1.147	-.671	-.607	-.429	-.367	-.429	-.155	-.155
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.003	.006	.003	.006	.006	.029	.029	.043	.050	.063	.057	.108	.140	.139	.116	.070	.102	.015	.015
					Pearson Residual	-.052	-.075	-.055	-.079	-.081	-.172	-.173	-.212	-.230	-.260	-.246	-.348	-.403	2.489	-.362	-.274	-.338	-.123	-.124
				Treatment	Observed	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0
					Expected	.010	.020	.010	.021	.022	.096	.093	.131	.143	.167	.139	.238	.269	.227	.166	.092	.124	.017	.017
					Pearson Residual	-.098	-.142	-.102	-.147	-.150	-.318	-.312	-.374	-.393	2.129	-.386	-.519	-.554	-.506	2.135	-.310	-.364	-.132	-.131
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.002	.005	.003	.006	.006	.026	.026	.039	.046	.059	.054	.104	.138	.142	.122	.075	.113	.017	.017
					Pearson Residual	-.049	-.071	-.052	-.075	-.076	-.163	-.164	-.202	-.220	-.250	4.197	-.340	-.401	-.407	-.373	-.285	-.357	-.130	-.131
				Treatment	Observed	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.009	.018	.009	.019	.020	.087	.085	.121	.134	.159	.135	.236	.272	.240	.180	.100	.138	.019	.019
					Pearson Residual	-.093	-.134	-.097	-.139	-.142	-.301	3.215	-.358	-.379	-.416	-.380	-.517	1.500	-.522	-.444	-.325	-.385	-.140	-.139
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.006	.012	.006	.013	.013	.057	.054	.074	.079	.089	.072	.118	.126	.103	.073	.039	.052	.007	.007
					Pearson Residual	-.077	-.110	-.080	-.114	-.116	-.245	4.196	-.283	-.292	-.312	-.278	-.366	-.380	-.339	-.280	-.202	-.234	-.085	-.084
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.003	.006	.003	.007	.007	.032	.032	.047	.054	.068	.060	.111	.140	.135	.109	.064	.093	.013	.013
					Pearson Residual	-.055	-.080	-.058	-.084	-.085	-.182	-.182	-.222	-.240	-.269	-.252	-.354	-.404	-.395	2.855	-.262	-.320	-.116	-.117
	Above Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.010	.020	.010	.021	.021	.086	.076	.097	.094	.097	.071	.107	.101	.074	.048	.025	.032	.004	.004
					Pearson Residual	-.100	-.143	-.102	-.146	-.147	-.308	-.287	-.327	3.102	-.327	-.277	-.346	-.336	-.283	-.226	-.160	-.181	-.065	-.065
		Student	High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.007	.013	.007	.014	.015	.062	.058	.079	.083	.092	.072	.117	.122	.097	.067	.036	.047	.006	.006
					Pearson Residual	-.081	-.116	-.084	-.120	-.122	-.258	-.249	-.293	-.300	-.317	-.280	-.364	-.372	3.053	-.268	-.192	-.222	-.080	-.080
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.014	.028	.014	.028	.028	.110	.091	.109	.095	.066	.094	.083	.058	.058	.036	.018	.023	.003	.003
					Pearson Residual	-.118	-.169	-.120	-.171	-.170	-.352	-.317	-.350	-.331	-.324	3.754	-.321	-.301	-.247	-.194	-.136	-.153	-.055	-.055
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.013	.026	.013	.026	.026	.105	.088	.106	.098	.096	.068	.097	.087	.061	.039	.020	.025	.003	.003
					Pearson Residual	-.114	-.163	-.116	-.165	-.165	-.342	-.311	2.897	-.330	-.326	-.270	-.328	-.309	-.255	-.201	-.141	-.159	-.057	-.057
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0
					Expected	.023	.046	.024	.048	.048	.193	.166	.205	.194	.193	.139	.203	.187	.133	.086	.043	.055	.007	.007
					Pearson Residual	-.152	-.217	-.155	-.221	-.222	-.462	-.425	1.854	1.929	-.463	-.387	-.475	-.454	-.378	-.299	-.211	-.238	-.086	-.085
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
					Expected	.031	.062	.031	.063	.062	.238	.192	.224	.198	.186	.128	.177	.154	.105	.065	.033	.041	.005	.005
					Pearson Residual	-.177	-.253	-.179	-.254	-.252	-.520	-.461	-.502	-.469	-.453	-.369	-.441	-.408	2.836	-.260	5.403	-.204	-.073	-.073
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.008	.017	.009	.018	.018	.075	.068	.089	.089	.095	.073	.113	.111	.084	.057	.029	.038	.005	.005
					Pearson Residual	-.091	-.130	-.093	-.134	-.135	-.284	-.269	-.312	-.313	-.325	-.280	-.356	-.354	-.304	-.245	5.746	-.199	-.072	-.071
		Retired	Medium Deprivation	Treatment	Observed	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.063	.120	.058	.110	.102	.345	.231	.229	.174	.144	.089	.113	.089	.057	.034	.016	.020	.003	.003
					Pearson Residual	-.255	2.626	-.244	-.341	-.328	-.845	1.699	-.509	-.437	-.394	-.306	-.346	-.305	-.242	-.185	-.128	-.143	-.051	-.051
Female	Below Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0
					Expected	.007	.016	.008	.017	.018	.080	.081	.120	.142	.180	.164	.315	.417	.424	.362	.221	.330	.049	.049
					Pearson Residual	-.087	-.125	-.091	-.131	-.134	-.286	2.283	-.354	-.386	-.438	-.416	-.593	-.696	.963	-.641	-.489	1.235	-.223	-.224
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.002	.005	.003	.005	.006	.025	.025	.038	.045	.057	.052	.102	.138	.143	.125	.078	.117	.017	.018
					Pearson Residual	-.048	-.069	-.050	-.073	-.074	-.159	-.160	-.198	-.216	-.246	-.235	-.337	-.399	-.409	-.377	3.450	-.365	-.133	-.134
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0
					Expected	.004	.009	.005	.009	.010	.044	.045	.068	.082	.106	.098	.195	.270	.291	.261	.166	.258	.039	.040
					Pearson Residual	-.064	-.093	-.067	-.097	-.099	-.213	-.215	-.266	-.292	-.334	-.321	-.465	-.559	-.583	-.548	-.426	3.673	-.200	-.202
		Student	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0
					Expected	.007	.015	.008	.016	.017	.073	.073	.106	.120	.146	.127	.230	.279	.258	.201	.116	.163	.023	.023
					Pearson Residual	-.084	-.122	-.088	-.127	-.130	-.276	-.275	-.334	-.357	-.397	-.368	-.510	1.473	-.544	-.473	-.350	2.163	-.153	-.153
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.003	.006	.003	.007	.007	.031	.031	.045	.053	.066	.059	.110	.140	.137	.112	.066	.096	.014	.014
					Pearson Residual	-.054	-.078	-.057	-.082	-.083	-.178	-.178	-.218	-.236	-.266	-.250	2.842	-.404	-.398	-.355	-.267	-.327	-.119	-.119
		Employed full-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0
					Expected	.006	.012	.007	.014	.014	.064	.066	.100	.120	.156	.145	.288	.403	.437	.396	.254	.397	.060	.062
					Pearson Residual	-.077	-.112	-.081	-.117	-.120	-.256	-.259	-.321	-.353	2.199	-.390	1.394	1.012	-.715	-.676	-.527	-.876	-.248	-.251
				Treatment	Observed	0	0	0	0	0	0	1	0	1	0	0	1	0	1	0	0	0	0	1
					Expected	.018	.036	.019	.040	.041	.182	.180	.262	.298	.364	.317	.575	.697	.646	.505	.291	.411	.058	.058
					Pearson Residual	-.133	-.192	-.139	-.200	-.204	-.435	1.966	-.526	1.324	-.603	-.581	-.806	-.900	.472	-.750	-.556	-.669	-.243	3.917
				6	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.002	.004	.002	.004	.004	.019	.019	.029	.035	.047	.044	.090	.129	.147	.139	.092	.149	.023	.024
					Pearson Residual	-.041	-.060	-.043	-.063	-.064	-.138	-.140	-.173	-.191	-.221	-.215	-.314	-.385	2.413	-.401	-.318	-.418	-.154	-.156
			Medium Deprivation	Treatment	Observed	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.010	.020	.011	.022	.023	.102	.101	.148	.170	.210	.184	.339	.420	.397	.317	.185	.264	.038	.038
					Pearson Residual	-.099	-.143	-.104	-.149	6.467	-.325	-.324	-.395	-.425	-.443	-.435	1.204	-.699	1.026	-.595	-.444	-.538	-.196	-.196
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	1	0	0
					Expected	.012	.024	.013	.026	.027	.122	.122	.181	.210	.262	.234	.440	.560	.548	.449	.267	.389	.056	.057
					Pearson Residual	-.108	-.155	-.113	-.163	-.166	-.355	-.355	-.435	-.471	-.530	-.499	-.703	3.514	-.797	-.711	1.466	-.656	-.239	-.240
		Employed part-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.006	.013	.007	.013	.014	.059	.056	.076	.080	.090	.072	.118	.125	.100	.070	.038	.050	.007	.007
					Pearson Residual	-.078	-.113	-.081	-.117	-.118	-.250	-.242	-.287	-.296	-.315	-.279	-.366	-.377	2.992	-.275	-.198	-.229	-.083	-.082
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.010	.020	.010	.021	.021	.087	.077	.097	.094	.097	.071	.108	.101	.073	.048	.025	.031	.004	.004
					Pearson Residual	-.100	-.144	-.103	-.147	-.148	-.309	-.288	-.329	-.323	-.327	-.277	2.897	-.334	-.282	-.224	-.158	-.180	-.065	-.064
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.005	.010	.005	.011	.012	.050	.048	.067	.073	.085	.070	.119	.132	.111	.081	.044	.060	.008	.008
					Pearson Residual	-.071	-.102	-.074	-.106	-.108	-.229	-.225	-.269	-.281	-.304	-.274	-.367	-.390	2.825	-.296	-.215	-.252	-.091	-.091
		Self-employed	Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.004	.008	.004	.008	.009	.038	.037	.054	.061	.074	.064	.116	.139	.128	.099	.057	.080	.011	.011
					Pearson Residual	-.061	-.087	-.063	-.091	-.093	-.198	-.194	-.239	-.255	-.283	-.262	-.362	-.402	2.616	-.331	-.245	-.294	-.107	-.107
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.004	.008	.004	.008	.009	.040	.041	.062	.075	.098	.092	.185	.264	.293	.271	.177	.282	.043	.044
					Pearson Residual	-.061	-.088	-.064	-.092	-.094	-.201	-.204	-.253	-.279	-.321	3.065	-.452	-.551	-.586	1.505	-.441	-.573	-.211	-.213
				Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0
					Expected	.003	.006	.004	.007	.008	.034	.034	.049	.057	.070	.061	.113	.140	.133	.106	.062	.088	.013	.013
					Pearson Residual	-.057	-.082	-.060	-.086	-.088	-.187	-.187	4.389	-.245	-.274	-.256	-.357	-.404	-.391	-.344	-.256	-.311	-.113	-.113
	Above Undergraduate	Unemployed	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.004	.008	.004	.008	.009	.039	.038	.055	.062	.075	.065	.116	.139	.126	.097	.055	.077	.011	.011
					Pearson Residual	-.061	-.089	-.064	-.093	-.094	-.201	-.199	-.241	3.882	-.285	-.263	-.363	-.401	-.380	-.328	-.242	-.290	-.105	-.105
				Treatment	Observed	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.007	.014	.007	.015	.015	.063	.069	.080	.092	.073	.117	.121	.096	.066	.035	.046	.006	.006	
					Pearson Residual	-.082	-.118	-.085	-.122	-.123	3.843	-.251	-.295	-.301	-.318	-.280	-.364	-.371	-.325	-.296	-.190	-.220	-.079	-.079
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.006	.013	.007	.014	.014	.059	.056	.076	.081	.090	.072	.118	.124	.100	.070	.037	.050	.007	.007
					Pearson Residual	-.079	-.113	-.082	-.117	-.119	-.251	-.243	-.288	-.296	-.315	-.279	2.736	-.377	-.333	-.274	-.197	-.228	-.082	-.082
			High Deprivation	No Treatment	Observed	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.003	.006	.003	.007	.007	.032	.032	.048	.055	.068	.060	.112	.140	.134	.108	.064	.092	.013	.013
					Pearson Residual	17.941	-.080	-.058	-.084	-.086	-.183	-.183	-.224	-.241	-.270	-.253	-.355	-.404	-.394	-.349	-.261	-.318	-.116	-.116
		Student	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.005	.010	.005	.011	.011	.049	.047	.067	.073	.084	.070	.119	.132	.112	.082	.045	.061	.008	.008
					Pearson Residual	-.071	-.102	-.073	-.106	-.107	-.228	-.223	3.742	-.280	-.304	-.274	-.367	-.390	-.355	-.298	-.216	-.254	-.092	-.092
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.009	.018	.009	.019	.019	.079	.071	.092	.091	.096	.072	.111	.107	.080	.053	.028	.036	.005	.005
					Pearson Residual	-.094	-.135	-.097	-.139	-.139	-.293	-.276	-.318	-.317	-.326	-.279	-.353	-.336	2.883	-.256	-.237	-.168	-.192	-.069
		Employed full-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0
					Expected	.011	.022	.011	.024	.024	.105	.100	.139	.150	.173	.141	.238	.260	.217	.156	.085	.114	.016	.016
					Pearson Residual	-.103	-.149	-.107	-.154	-.157	-.332	-.325	-.387	-.403	-.435	2.368	-.519	-.546	1.782	-.543	-.297	-.347	-.125	-.125
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	1	2	1	1	0	0	0
					Expected	.075	.152	.079	.160	.162	.667	.592	.759	.745	.772	.575	.868	.831	.614	.403	.207	.267	.036	.035
					Pearson Residual	-.275	2.191	-.283	-.404	-.407	-.853	-.800	-.916	-.906	.273	.582	.149	1.356	.513	.964	-.461	-.525	-.189	-.188
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	0
					Expected	.034	.071	.037	.077	.079	.343	.330	.464	.506	.589	.488	.832	.927	.788	.574	.315	.427	.059	.059
					Pearson Residual	-.186	-.268	-.194	-.278	-.283	-.600	1.195	-.705	.720	-.724	-.972	.081	-.942	.586	-.575	.904	-.244	-.243	
				Treatment	Observed	0	0	0	0	0	2	0	0	0	0	2	0	2	1	0	1	0	0	0
					Expected	.069	.141	.073	.149	.151	.628	.564	.733	.768	.579	.887	.863	.647	.430	.222	.287	.038	.038	
					Pearson Residual	-.265	-.379	-.272	-.390	-.393	1.804	-.779	-.898	-.896	1.479	-.790	1.253	.156	-.839	-.674	-.478	1.355	-.197	-.195

Cell Information

Frequency

Factor1_Adaptability

Gender	Education	Occupational Status	IMD Score (Binned)	Treatment		1.20	1.60	1.80	2.00	2.20	2.40	2.60	2.80	3.00	3.20	3.40	3.60	3.80	4.00	4.20	4.40	4.60	4.80	5.00
			High Deprivation	No Treatment	Observed	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	1	0
					Expected	.017	.036	.019	.039	.040	.177	.172	.245	.272	.321	.271	.473	.543	.475	.355	.198	.271	.038	.038
					Pearson Residual	-.132	-.191	-.138	-.199	-.202	2.003	-.424	-.511	-.540	1.248	-.539	-.732	-.793	-.734	-.624	-.456	1.448	4.970	-.195
				Treatment	Observed	0	0	0	1	0	2	0	1	0	1	0	1	2	0	2	1	0	0	0
					Expected	.085	.173	.090	.184	.188	.787	.719	.951	.967	1.041	.801	1.254	1.252	.961	.648	.339	.441	.059	.059
					Pearson Residual	-.293	-.420	-.302	1.916	-.437	1.419	-.877	.052	-1.030	-.042	-.929	-.241	.710	-1.026	1.731	1.154	-.678	-.244	-.243
		Employed part-time	Low Deprivation	Treatment	Observed	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.057	.109	.053	.102	.096	.330	.229	.232	.180	.152	.095	.122	.097	.062	.037	.018	.022	.003	.003
					Pearson Residual	-.242	-.339	-.234	-.328	2.994	-.829	-.508	-.513	2.023	-.405	-.316	-.360	-.320	-.254	-.195	-.135	-.150	-.054	-.054
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.053	.102	.050	.096	.091	.319	.226	.234	.184	.157	.100	.128	.103	.067	.040	.020	.024	.003	.003
					Pearson Residual	-.232	-.327	-.226	-.318	-.309	1.314	1.729	-.514	-.451	-.413	-.324	-.371	-.330	-.263	-.202	-.140	-.156	-.056	-.056
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.013	.027	.014	.028	.027	.108	.090	.095	.067	.067	.095	.067	.085	.059	.037	.019	.024	.003	.003
					Pearson Residual	-.116	-.166	-.118	-.168	-.168	-.348	-.314	-.348	-.331	-.325	3.733	-.324	-.304	-.251	-.197	-.138	-.156	-.056	-.056
				Treatment	Observed	0	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.070	.137	.068	.132	.126	.453	.331	.351	.284	.247	.159	.208	.170	.111	.067	.033	.041	.005	.005
					Pearson Residual	-.268	-.379	3.614	-.372	-.363	.882	-.610	-.631	-.560	-.519	-.410	1.798	-.425	-.339	-.262	-.182	-.203	-.073	-.072
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.021	.043	.022	.044	.045	.182	.158	.199	.194	.141	.209	.195	.142	.092	.047	.060	.024	.008	.008
					Pearson Residual	-.146	-.209	-.149	4.583	-.214	-.447	-.415	1.892	-.459	-.463	-.390	-.483	-.465	-.390	-.310	-.219	-.248	-.089	-.089
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.006	.011	.006	.012	.013	.054	.051	.071	.077	.087	.071	.119	.129	.106	.076	.041	.055	.008	.007
					Pearson Residual	-.074	-.107	-.077	-.111	-.113	-.239	-.233	-.277	-.288	-.310	-.277	2.724	-.384	-.345	-.286	-.207	-.241	-.087	-.087
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.009	.018	.009	.019	.019	.078	.070	.092	.091	.096	.072	.111	.108	.081	.054	.028	.036	.005	.005
					Pearson Residual	-.093	-.134	-.096	-.138	-.139	-.292	-.275	3.151	-.317	-.326	-.279	-.353	-.348	-.297	-.238	-.169	-.193	-.070	-.069
		Retired	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.012	.025	.013	.025	.025	.101	.086	.105	.098	.096	.069	.099	.090	.063	.040	.020	.026	.003	.003
					Pearson Residual	-.111	-.159	-.113	-.161	-.161	-.336	-.306	-.342	-.329	-.326	3.686	-.331	-.314	-.260	-.205	-.144	-.163	-.059	-.058
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.019	.038	.019	.037	.036	.135	.104	.116	.098	.088	.059	.079	.066	.044	.027	.013	.017	.002	.002
					Pearson Residual	-.140	-.198	-.139	-.197	-.194	-.395	-.341	-.362	-.330	-.311	-.250	3.754	-.293	-.215	-.167	-.116	-.130	-.047	-.046
Non-binary / third gender	Below Undergraduate	Self-employed	Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.007	.015	.008	.016	.017	.070	.064	.085	.087	.094	.073	.115	.115	.089	.060	.032	.041	.006	.006
					Pearson Residual	-.087	-.125	-.090	-.129	-.130	-.274	-.261	-.305	-.309	-.322	3.568	-.360	-.361	-.313	-.254	-.181	-.208	-.075	-.074
Prefer not to say	Above Undergraduate	Unemployed	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
					Expected	.012	.024	.012	.024	.025	.098	.084	.103	.097	.097	.069	.101	.092	.065	.042	.021	.027	.004	.004
					Pearson Residual	-.109	-.156	-.111	-.158	-.159	-.330	-.303	-.340	3.048	-.327	-.273	-.334	-.318	-.264	-.209	-.147	-.166	-.060	-.059
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.031	.059	.029	.055	.051	.172	.116	.115	.088	.072	.045	.057	.045	.029	.017	.008	.010	.001	.001
					Pearson Residual	-.179	-.251	-.172	-.240	-.231	-.455	-.362	2.776	-.310	-.279	-.217	-.246	-.217	-.172	-.132	-.091	-.101	-.036	-.036

Factor 2

Case Processing Summary

		N	Marginal Percentage
Factor2_CreativeThinking	2.43	1	0.8%
	2.71	2	1.7%
	2.86	2	1.7%
	3.00	5	4.1%
	3.14	3	2.5%
	3.29	2	1.7%
	3.43	5	4.1%
	3.57	4	3.3%
	3.71	11	9.1%
	3.86	11	9.1%
	4.00	12	9.9%
	4.14	14	11.6%
	4.29	10	8.3%
	4.43	14	11.6%
	4.57	9	7.4%
	4.71	5	4.1%
	4.86	5	4.1%
	5.00	6	5.0%
Gender	Male	26	21.5%
	Female	92	76.0%
	Non-binary / third gender	1	0.8%
	Prefer not to say	2	1.7%
Education	Below Undergraduate	48	39.7%
	Above Undergraduate	73	60.3%
Occupational_Status	Unemployed	14	11.6%
	Student	8	6.6%
	Employed full-time	70	57.9%
	Employed part-time	11	9.1%
	Self-employed	14	11.6%
	Retired	4	3.3%
IMD_Score (Binned)	Low Deprivation	41	33.9%
	Medium Deprivation	39	32.2%
	High Deprivation	41	33.9%
Treatment	No Treatment	32	26.4%
	Treatment	88	72.7%
	6	1	0.8%
Valid		121	100.0%
Missing		46	
Total		167	

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	519.885			
Final	492.819	27.066	13	.012

Link function: Logit.

Goodness-of-Fit

	Chi-Square	df	Sig.
Pearson	913.043	973	.915
Deviance	412.969	973	1.000

Link function: Logit.

Parameter Estimates

		Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Threshold	[Factor2_CreativeThinking = 2.43]	-4.462	2.586	2.978	1	.084	-9.529	.606
	[Factor2_CreativeThinking = 2.71]	-3.301	2.453	1.810	1	.178	-8.109	1.507
	[Factor2_CreativeThinking = 2.86]	-2.739	2.426	1.275	1	.259	-7.494	2.015
	[Factor2_CreativeThinking = 3.00]	-1.971	2.405	.672	1	.412	-6.685	2.743
	[Factor2_CreativeThinking = 3.14]	-1.671	2.400	.485	1	.486	-6.376	3.033
	[Factor2_CreativeThinking = 3.29]	-1.503	2.398	.393	1	.531	-6.204	3.197
	[Factor2_CreativeThinking = 3.43]	-1.153	2.395	.232	1	.630	-5.847	3.541
	[Factor2_CreativeThinking = 3.57]	-.924	2.393	.149	1	.700	-5.615	3.767
	[Factor2_CreativeThinking = 3.71]	-.399	2.391	.028	1	.868	-5.086	4.288
	[Factor2_CreativeThinking = 3.86]	.054	2.391	.001	1	.982	-4.633	4.741
	[Factor2_CreativeThinking = 4.00]	.532	2.392	.049	1	.824	-4.157	5.221
	[Factor2_CreativeThinking = 4.14]	1.105	2.394	.213	1	.644	-3.588	5.798
	[Factor2_CreativeThinking = 4.29]	1.523	2.396	.404	1	.525	-3.174	6.220
	[Factor2_CreativeThinking = 4.43]	2.196	2.401	.837	1	.360	-2.509	6.901
	[Factor2_CreativeThinking = 4.57]	2.803	2.406	1.357	1	.244	-1.913	7.518
	[Factor2_CreativeThinking = 4.71]	3.280	2.412	1.849	1	.174	-1.447	8.008
	[Factor2_CreativeThinking = 4.86]	3.986	2.429	2.694	1	.101	-.774	8.746
Location	[Gender=1]	-1.449	1.333	1.181	1	.277	-4.062	1.164
	[Gender=2]	-.389	1.280	.092	1	.761	-2.897	2.120
	[Gender=3]	2.666	2.287	1.359	1	.244	-1.817	7.149
	[Gender=4]	0ª	.	.	0	.	.	.
	[Education=0]	-.583	.355	2.696	1	.101	-1.278	.113
	[Education=1]	0ª	.	.	0	.	.	.
	[Occupational_Status=1]	.093	1.040	.008	1	.929	-1.945	2.132
	[Occupational_Status=2]	1.622	1.104	2.156	1	.142	-.543	3.786
	[Occupational_Status=3]	.380	.927	.168	1	.682	-1.438	2.197
	[Occupational_Status=4]	.762	1.058	.520	1	.471	-1.310	2.835
	[Occupational_Status=5]	-.061	1.024	.003	1	.953	-2.068	1.947
	[Occupational_Status=6]	0ª	.	.	0	.	.	.
	[IMD_Group=1]	.885	.400	4.890	1	.027	.101	1.669
	[IMD_Group=2]	-.019	.400	.002	1	.962	-.803	.765
	[IMD_Group=3]	0ª	.	.	0	.	.	.
	[Treatment=0]	.252	1.810	.019	1	.889	-3.296	3.800
	[Treatment=1]	1.038	1.785	.338	1	.561	-2.462	4.537
	[Treatment=6]	0ª	.	.	0	.	.	.

Link function: Logit.

a. This parameter is set to zero because it is redundant.

STRENGTH-BASED CHARACTERISTICS IN ADULTS WITH ADHD

Cell Information

Frequency

Gender	Education	Occupational_Status	IMD_Score (Binned)	Treatment		2.43	2.71	2.86	3.00	3.14	3.29	3.43	3.57	3.71	3.86	4.00	4.14	4.29	4.43	4.57	4.71	4.86	5.00
Male	Below Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.012	.025	.026	.062	.036	.024	.059	.045	.118	.112	.116	.121	.069	.078	.042	.021	.018	.018
					Pearson Residual	-.108	-.159	-.162	-.258	-.194	-.156	-.249	-.216	-.366	-.355	2.760	-.370	-.272	-.291	-.210	-.145	-.134	-.135
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.028	.056	.054	.118	.061	.037	.084	.057	.129	.099	.085	.074	.037	.038	.019	.009	.008	.007
					Pearson Residual	-.169	-.243	-.239	-.366	-.255	-.197	-.302	-.246	-.384	-.332	3.278	-.283	-.197	-.199	-.140	-.095	-.087	-.087
		Student	Medium Deprivation	Treatment	Observed	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.006	.013	.014	.036	.022	.015	.039	.031	.090	.097	.116	.141	.092	.116	.069	.036	.032	.033
					Pearson Residual	-.079	-.117	-.120	5.138	-.151	-.124	-.201	-.179	-.314	-.328	-.362	-.405	-.319	-.363	-.273	-.192	-.181	-.185
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.006	.013	.014	.036	.022	.015	.038	.031	.089	.097	.116	.141	.093	.118	.070	.036	.032	.034
					Pearson Residual	-.079	-.116	-.119	-.193	-.150	-.123	-.199	-.178	-.312	3.056	-.362	-.405	-.320	-.365	-.275	-.194	-.182	-.187
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0
					Expected	.026	.056	.059	.147	.088	.059	.147	.115	.319	.323	.356	.397	.241	.285	.161	.080	.070	.071
					Pearson Residual	-.163	-.239	-.245	-.394	-.301	-.245	-.393	2.658	-.597	-.601	-.636	-.676	-.512	1.407	2.152	-.287	-.267	-.270
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
					Expected	.046	.087	.079	.155	.072	.042	.087	.055	.114	.079	.062	.050	.024	.024	.012	.005	.005	.004
					Pearson Residual	-.218	-.308	-.292	-.428	-.278	-.208	-.309	-.242	-.358	-.292	3.891	-.230	-.157	-.156	-.109	-.074	-.068	-.067
				Treatment	Observed	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.043	.087	.087	.199	.107	.067	.155	.110	.214	.194	.176	.091	.096	.049	.023	.020	.020	.020
					Pearson Residual	-.209	-.302	-.302	1.894	-.337	-.264	-.410	-.341	-.548	-.490	1.928	-.440	-.310	-.318	-.224	-.153	-.141	-.140
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.045	.085	.078	.153	.072	.042	.087	.055	.114	.079	.063	.051	.024	.024	.012	.006	.005	.005
					Pearson Residual	-.216	-.305	-.290	-.426	-.278	-.208	-.309	-.242	-.359	3.407	-.259	-.232	-.158	-.158	-.110	-.075	-.068	-.068
				Treatment	Observed	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
					Expected	.042	.086	.086	.196	.106	.067	.154	.110	.261	.215	.195	.178	.093	.098	.050	.024	.020	.020
					Pearson Residual	-.207	-.299	-.299	-.466	-.335	-.263	-.409	-.340	1.552	1.792	-.465	-.443	-.312	-.320	-.226	-.155	-.142	-.142
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.013	.028	.029	.071	.041	.026	.064	.048	.123	.113	.113	.113	.063	.070	.037	.018	.015	.015
					Pearson Residual	-.117	-.171	-.174	-.276	-.206	6.079	-.261	-.224	-.375	-.357	-.356	-.357	-.259	-.274	-.196	-.135	-.125	-.125
			Medium Deprivation	No Treatment	Observed	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.069	.122	.102	.179	.075	.041	.082	.049	.093	.060	.045	.035	.016	.016	.008	.004	.003	.003
					Pearson Residual	-.272	2.678	-.337	-.467	-.284	-.207	-.298	-.226	-.321	-.252	-.216	-.190	-.128	-.127	-.088	-.060	-.054	-.054
	Above Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.007	.014	.015	.038	.023	.016	.040	.032	.092	.099	.117	.140	.091	.114	.067	.034	.030	.032
					Pearson Residual	-.081	-.119	-.123	-.194	-.154	-.126	-.204	-.182	3.143	-.331	-.363	-.404	-.358	-.269	-.189	-.177	-.181	-.181
		Student	High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.007	.016	.017	.043	.026	.017	.044	.035	.099	.103	.118	.137	.086	.105	.060	.030	.027	.028
					Pearson Residual	-.087	-.128	-.132	-.212	-.163	-.133	-.215	-.191	3.018	-.340	-.366	-.399	-.307	-.342	-.254	-.177	-.166	-.168
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.005	.011	.011	.029	.018	.012	.032	.026	.078	.088	.110	.142	.099	.132	.082	.043	.039	.042
					Pearson Residual	-.070	-.103	-.107	5.763	-.136	-.112	-.182	-.164	-.290	-.310	-.352	-.407	-.331	-.389	-.300	-.213	-.202	-.209
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.012	.025	.026	.064	.037	.024	.060	.045	.119	.112	.115	.119	.068	.076	.041	.020	.017	.017
					Pearson Residual	-.110	-.161	-.164	-.262	-.197	-.158	-.252	-.218	-.368	2.810	-.361	-.367	-.269	-.287	-.207	-.143	-.132	-.133
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
					Expected	.024	.050	.052	.126	.074	.048	.118	.090	.237	.224	.232	.240	.137	.154	.084	.041	.035	.035
					Pearson Residual	-.154	-.226	-.230	-.367	-.277	-.222	-.354	-.307	-.519	-.503	-.512	1.656	-.383	2.241	-.295	-.204	-.189	-.190
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.015	.032	.034	.087	.053	.035	.089	.071	.199	.208	.237	.274	.171	.208	.120	.060	.053	.055
					Pearson Residual	-.124	-.182	-.187	-.301	4.189	-.189	-.305	-.270	-.470	-.481	-.518	1.495	-.433	-.482	-.357	-.249	-.233	-.237
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.040	.077	.071	.145	.070	.041	.087	.056	.119	.085	.068	.056	.027	.027	.013	.006	.005	.005
					Pearson Residual	-.203	-.289	-.277	-.412	-.274	-.207	-.309	-.245	2.720	-.304	-.270	-.244	-.167	-.167	-.117	-.079	-.072	-.072
		Retired	Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0
					Expected	.035	.072	.073	.172	.096	.061	.144	.105	.258	.222	.209	.198	.106	.114	.059	.028	.024	.024
					Pearson Residual	-.188	-.274	-.276	-.434	-.317	-.251	-.394	-.332	-.544	-.500	-.484	4.261	-.335	-.347	-.247	-.169	-.155	-.155
Female	Below Undergraduate	Unemployed	Low Deprivation	Treatment	Observed	0	0	1	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0
					Expected	.012	.026	.028	.073	.046	.032	.082	.068	.205	.240	.311	.422	.307	.427	.279	.151	.139	.150
					Pearson Residual	-.110	-.163	5.806	-.274	-.216	-.179	-.291	3.621	-.470	-.510	-.589	-.701	-.584	.946	-.555	-.399	-.382	-.398
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.010	.021	.022	.055	.032	.021	.053	.041	.112	.110	.118	.127	.075	.087	.048	.024	.021	.021
					Pearson Residual	-.100	-.147	-.150	-.241	-.183	-.148	-.237	-.207	-.355	-.352	-.366	-.382	-.285	3.236	-.225	-.156	-.145	-.146
			High Deprivation	Treatment	Observed	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.019	.041	.043	.108	.064	.042	.105	.082	.222	.220	.237	.256	.152	.177	.098	.048	.042	.043
					Pearson Residual	-.140	-.206	-.211	-.338	3.760	-.208	-.334	-.292	1.751	-.497	-.518	-.542	-.406	-.440	-.321	-.223	-.207	-.209
		Student	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
					Expected	.002	.004	.004	.011	.007	.005	.014	.012	.039	.052	.081	.145	.144	.295	.300	.225	.269	.392
					Pearson Residual	-.042	-.062	-.065	-.106	-.085	-.071	-.117	-.109	-.198	-.230	-.290	-.395	-.394	-.589	-.595	-.504	-.557	2.866
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.002	.005	.005	.013	.008	.006	.016	.013	.042	.053	.076	.119	.101	.166	.129	.078	.078	.091
					Pearson Residual	-.046	-.068	-.071	-.116	-.093	-.077	-.126	-.116	-.209	-.236	-.287	-.367	-.334	2.245	-.384	-.291	-.290	-.317
		Employed full-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0
					Expected	.020	.043	.046	.116	.071	.048	.122	.097	.279	.299	.351	.419	.271	.337	.199	.101	.090	.093
					Pearson Residual	-.142	-.208	-.215	-.347	-.269	-.220	-.356	-.317	-.555	-.576	2.962	-.698	1.470	-.616	-.461	-.324	-.304	-.310
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	1	1	1	0	1	1
					Expected	.015	.033	.036	.094	.059	.041	.107	.090	.278	.338	.460	.668	.520	.780	.548	.310	.295	.328
					Pearson Residual	-.123	-.182	-.190	-.309	-.245	-.203	-.331	-.302	-.543	-.602	-.712	.437	.703	.272	-.784	-.575	1.340	1.212
				6	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.009	.018	.019	.048	.029	.019	.048	.038	.105	.107	.119	.133	.081	.096	.055	.027	.024	.024
					Pearson Residual	-.093	-.136	-.140	-.225	-.172	-.140	-.225	-.198	-.343	-.346	2.723	-.392	-.297	-.327	-.240	-.167	-.156	-.158
			Medium Deprivation	Treatment	Observed	0	1	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
					Expected	.022	.048	.051	.129	.078	.052	.132	.105	.296	.310	.355	.411	.258	.315	.182	.092	.080	.083
					Pearson Residual	-.150	4.380	-.228	-.366	-.283	-.231	-.372	-.330	1.361	-.588	1.153	-.690	-.532	-.593	-.440	-.307	-.288	-.292
			High Deprivation	Treatment	Observed	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0
					Expected	.029	.063	.067	.169	.102	.069	.174	.138	.391	.411	.473	.550	.347	.424	.246	.124	.109	.113
					Pearson Residual	-.172	-.253	-.260	2.069	-.324	-.264	-.427	-.378	2.707	-.677	-.732	-.799	-.617	-.689	1.570	-.358	-.335	-.341
		Employed part-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.005	.010	.011	.027	.017	.012	.030	.025	.074	.085	.108	.142	.100	.136	.087	.046	.042	.045
					Pearson Residual	-.068	-.100	-.103	-.168	-.132	-.108	-.176	-.159	-.283	-.304	-.348	-.407	2.995	-.397	-.308	-.220	-.209	-.217
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
					Expected	.005	.011	.012	.030	.019	.013	.033	.027	.080	.090	.111	.142	.098	.129	.080	.042	.038	.040
					Pearson Residual	-.072	-.106	-.109	-.177	-.139	-.114	-.185	-.166	-.295	-.314	-.354	2.455	-.329	-.385	-.295	-.209	-.198	-.204
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
					Expected	.011	.023	.024	.059	.035	.023	.057	.043	.116	.112	.117	.123	.071	.081	.044	.022	.019	.019
					Pearson Residual	-.105	-.154	-.157	-.251	-.190	-.153	-.245	-.213	-.362	2.823	-.364	-.375	-.277	-.298	-.216	-.149	-.138	-.139
		Self-employed	Medium Deprivation	Treatment	Observed	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
					Expected	.012	.024	.025	.062	.036	.024	.058	.045	.118	.112	.116	.121	.069	.078	.042	.021	.018	.018
					Pearson Residual	9.247	-.158	-.162	-.258	-.194	-.156	-.249	-.216	-.366	-.355	-.362	-.370	-.273	-.291	-.210	-.145	-.135	-.135
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0
					Expected	.049	.100	.098	.219	.116	.072	.162	.113	.260	.206	.181	.161	.082	.085	.043	.020	.017	.017
					Pearson Residual	-.224	-.324	-.321	-.496	-.350	-.272	-.420	-.345	1.555	-.479	-.446	2.183	-.292	-.297	-.209	-.143	-.131	-.130
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
					Expected	.011	.024	.025	.061	.036	.024	.058	.044	.117	.112	.116	.122	.070	.079	.043	.021	.018	.018
					Pearson Residual	-.107	-.157	-.160	-.255	-.193	-.155	-.248	-.215	-.364	-.355	-.363	-.372	-.274	-.293	-.212	-.147	-.136	7.315
	Above Undergraduate	Unemployed	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
					Expected	.005	.011	.011	.030	.018	.013	.032	.026	.078	.088	.110	.142	.099	.131	.082	.043	.039	.041
					Pearson Residual	-.071	-.104	-.108	-.175	-.137	-.113	-.183	-.165	-.291	-.311	-.352	-.407	-.331	-.388	-.298	4.713	-.201	-.208
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.002	.005	.005	.014	.009	.006	.017	.014	.044	.055	.079	.122	.102	.165	.126	.075	.074	.086
					Pearson Residual	-.048	-.070	-.073	-.120	-.095	-.079	-.130	-.119	-.215	-.242	-.292	-.372	-.336	2.253	-.379	-.285	-.283	-.307
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.006	.012	.013	.033	.020	.014	.035	.029	.084	.093	.114	.142	.096	.124	.075	.039	.035	.037
					Pearson Residual	-.075	-.110	-.114	-.184	-.144	-.118	-.192	-.172	3.121	-.358	-.407	-.325	-.376	-.285	-.202	-.191	-.196	-.196
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.012	.025	.026	.064	.037	.024	.059	.045	.119	.112	.116	.119	.068	.076	.041	.020	.017	.017
					Pearson Residual	-.110	-.161	-.164	-.261	-.196	-.158	-.251	-.218	-.368	-.356	-.361	-.368	-.270	3.475	-.208	-.143	-.133	-.133
		Student	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.003	.006	.006	.016	.010	.007	.019	.016	.050	.062	.086	.129	.103	.161	.117	.068	.066	.074
					Pearson Residual	-.052	-.076	-.079	-.129	-.103	-.085	-.140	-.128	4.349	-.257	-.307	-.384	-.340	-.437	-.364	-.270	-.265	-.284
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
					Expected	.001	.003	.003	.008	.005	.003	.009	.008	.026	.034	.052	.089	.084	.161	.148	.102	.113	.150
					Pearson Residual	-.035	-.052	-.054	-.088	-.071	-.059	-.097	-.090	-.163	-.188	-.234	-.313	-.303	-.438	-.417	-.338	-.357	2.380
		Employed full-time	Low Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
					Expected	.007	.016	.017	.045	.028	.020	.051	.042	.129	.153	.201	.278	.206	.294	.196	.107	.100	.109
					Pearson Residual	-.086	-.128	-.132	-.215	-.170	-.141	-.229	-.208	-.372	-.406	-.473	3.519	-.480	-.587	-.466	-.337	-.324	-.339
				Treatment	Observed	0	0	0	0	0	0	1	0	0	1	0	1	1	0	0	0	3	0
					Expected	.014	.030	.032	.086	.055	.038	.102	.087	.278	.357	.528	.860	.763	1.333	1.108	.705	.730	.895
					Pearson Residual	-.117	-.173	-.180	-.294	-.235	-.196	2.832	-.296	-.537	1.100	-.752	.160	.286	-.316	-1.134	-.880	2.786	-1.004

STRENGTH-BASED CHARACTERISTICS IN ADULTS WITH ADHD

Cell Information

Frequency

Gender	Education	Occupational Status	IMD Score (Binned)	Treatment		2.43	2.71	2.86	3.00	3.14	3.29	3.43	3.57	3.71	3.86	4.00	4.14	4.29	4.43	4.57	4.71	4.86	5.00
												Factor2_CreativeThinking											
			Medium Deprivation	No Treatment	Observed	0	0	1	1	0	0	0	0	0	1	2	0	0	1	0	0	0	1
					Expected	.064	.136	.143	.358	.213	.142	.354	.276	.758	.760	.831	.915	.550	.645	.361	.179	.156	.159
					Pearson Residual	-.254	-.373	2.285	1.103	-.469	-.381	-.611	-.536	-.922	.292	1.367	-1.026	-.773	.463	-.617	-.429	-.399	2.134
				Treatment	Observed	0	0	0	0	0	0	0	1	0	0	0	1	0	1	3	2	0	0
					Expected	.033	.072	.078	.202	.127	.087	.226	.186	.561	.651	.840	1.129	.814	1.125	.729	.393	.360	.388
					Pearson Residual	-.183	-.270	-.281	-.456	-.359	-.296	-.482	1.911	-.777	-.842	-.969	-.131	-.952	-.127	2.789	2.628	-.614	-.639
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	1	1	0	1	1	0	0	0	0	0	0	0
					Expected	.036	.077	.081	.201	.120	.080	.200	.156	.430	.433	.475	.526	.317	.373	.210	.104	.090	.093
					Pearson Residual	-.190	-.279	-.287	-.460	-.352	3.286	1.837	-.403	-.694	.914	.812	-.778	-.587	-.642	-.470	-.327	-.304	-.308
				Treatment	Observed	0	0	0	0	1	0	1	1	0	1	1	1	1	2	2	0	0	0
					Expected	.045	.098	.105	.273	.171	.117	.305	.252	.761	.886	1.147	1.549	1.122	1.558	1.015	.548	.504	.543
					Pearson Residual	-.213	-.314	-.326	-.529	2.020	-.344	1.275	1.509	-.904	.127	-.145	-.476	-.121	.382	1.027	-.760	-.727	-.756
		Employed part-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
					Expected	.002	.005	.008	.015	.009	.007	.018	.015	.050	.066	.100	.174	.165	.319	.298	.208	.232	.312
					Pearson Residual	-.048	-.071	-.074	-.122	-.098	-.082	-.134	-.124	-.226	3.711	-.325	2.075	-.425	-.616	-.592	-.482	-.513	-.608
			Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
					Expected	.006	.012	.013	.035	.022	.015	.041	.034	.106	.130	.179	.263	.208	.316	.226	.129	.124	.139
					Pearson Residual	-.076	-.112	-.116	-.190	-.150	-.125	-.204	-.186	-.335	-.373	-.443	1.543	-.482	1.324	-.505	-.372	-.363	-.387
			High Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
					Expected	.006	.013	.014	.036	.022	.015	.038	.031	.089	.097	.116	.141	.093	.117	.070	.036	.032	.034
					Pearson Residual	-.079	-.116	-.119	-.193	-.150	-.123	-.199	-.178	-.313	-.327	-.362	-.405	-.320	-.365	3.637	-.194	-.182	-.186
				Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
					Expected	.008	.018	.020	.052	.033	.023	.060	.050	.157	.192	.266	.392	.311	.477	.342	.197	.189	.212
					Pearson Residual	-.092	-.136	-.141	-.230	-.183	-.151	-.248	-.226	-.407	-.453	-.540	-.672	3.196	-.753	-.621	-.459	1.930	-.478
		Self-employed	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0
					Expected	.005	.011	.012	.033	.021	.014	.038	.032	.100	.123	.172	.257	.207	.322	.235	.137	.132	.150
					Pearson Residual	-.073	-.107	-.112	-.182	-.145	-.120	-.197	-.180	-.324	-.362	-.433	-.543	-.480	-.619	1.680	2.420	-.376	-.403
			Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.014	.030	.031	.073	.042	.027	.065	.049	.124	.113	.112	.111	.061	.067	.036	.017	.015	.015
					Pearson Residual	-.120	-.175	-.177	-.281	-.209	-.167	3.786	-.226	-.377	-.356	-.354	-.353	-.255	-.268	-.192	-.132	-.122	-.122
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
					Expected	.006	.014	.015	.037	.023	.015	.039	.031	.091	.098	.116	.141	.092	.115	.068	.035	.031	.032
					Pearson Residual	-.080	-.118	-.122	-.196	-.153	-.125	-.202	-.180	-.316	-.330	-.363	-.404	3.149	-.361	-.271	-.191	-.179	-.183
		Retired	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
					Expected	.013	.028	.029	.070	.040	.026	.063	.047	.123	.113	.113	.114	.064	.070	.038	.018	.016	.016
					Pearson Residual	-.116	-.170	-.173	-.274	-.205	-.164	3.849	-.223	-.374	-.357	-.357	-.358	-.260	-.275	-.198	-.136	-.126	-.126
			High Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
					Expected	.006	.013	.014	.035	.022	.015	.037	.030	.088	.096	.115	.141	.093	.119	.071	.037	.033	.034
					Pearson Residual	-.078	-.114	-.118	-.191	-.149	-.122	-.197	-.177	3.223	-.326	-.361	-.406	-.321	-.368	-.277	-.196	-.184	-.189
Non-binary / third gender	Below Undergraduate	Self-employed	Medium Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
					Expected	.001	.001	.001	.004	.002	.002	.004	.004	.012	.017	.027	.051	.054	.121	.140	.119	.161	.280
					Pearson Residual	-.023	-.035	-.036	-.060	-.048	-.040	-.066	-.061	-.112	-.131	-.167	-.231	-.238	-.371	-.404	2.722	-.437	-.624
Prefer not to say	Above Undergraduate	Unemployed	Medium Deprivation	No Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.008	.018	.019	.047	.028	.019	.047	.037	.104	.106	.119	.134	.082	.099	.056	.028	.024	.025
					Pearson Residual	-.091	-.134	-.138	-.222	-.170	-.138	-.223	-.196	-.340	-.345	-.367	-.394	3.336	-.331	-.244	-.170	-.158	-.160
		Employed full-time	Low Deprivation	Treatment	Observed	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
					Expected	.001	.003	.003	.007	.005	.003	.009	.008	.025	.033	.050	.087	.082	.159	.149	.104	.117	.157
					Pearson Residual	-.034	-.050	-.052	-.086	-.069	-.058	-.095	-.087	-.159	-.184	-.229	-.308	3.336	-.435	-.418	-.341	-.363	-.431

Link function: Logit.

Appendix M: Reflective Journal

Reflective Extracts: SLR

Date	Title and Extract
	Search process and Covidence Today I started the *Title and Abstract* review on Covidence. For a person with ADHD, this seemed like a daunting and exceptionally overwhelming task. Confronted by a list of hundreds of articles to get through before even starting made me want to find an alternative task to do, or procrastinate. In fact I found myself being exceptionally good at avoiding this to begin with. However, when I eventually started it didn't seem too bad, as it didn't require too much of my concentration to briefly scan titles and abstracts. I decided to do 20 at a time, before taking a rest in between. In fact the ADHD symptoms became a strength at this point, as I am able to salient information quickly and make a instant decision. I am 80 papers in, and my focus is dwindling due to the repetition of the task. Though, I am quite surprised by how many irrelevant articles there are to screen out. I feel a little uncertain now, as I am wondering whether I have structure my search strategy correctly - what if my search doesn't pull up the most appropriate and relevant articles? Would I have to start all over again? *I can't read another 80 papers in addition to the remaining articles!* Many of the articles related to children with ADHD (when my focus is on adults), however I soon realised that due to the paucity of research in this area on adults, it makes sense that the majority of the studies are on children. As I trawled through I began to find a few relevant articles.
	Data Extraction I can't believe I thought synthesis was hard - this was on a whole new level. Reading paper after paper and trying to logically extract and summarise information felt like one of the most painful academic tasks I've done to date. It dragged on for three weeks, largely because I really struggle with reading large

volumes of dense material. My working memory makes it hard to hold onto what I've just read, let alone distil it into neat, meaningful summaries. On top of that, academic writing styles often feel unnecessarily convoluted - the kind that makes me want to close the tab and walk away.

Interestingly, this frustration made me think a lot about the kind of writer I *don't* want to be. I realised how much I value clarity, accessibility, and flow. I want my thesis to be digestible - something a curious layperson could pick up and follow without feeling lost or alienated.

Also, I'll admit, what made this whole thing marginally more bearable was putting it all into a table… and making it look aesthetically pleasing. Silver linings.

This experience directly shaped my commitment to writing in a style that prioritises clarity and coherence. I made conscious choices to use shorter sentences, logical structuring, and plain language where possible, aiming to make my thesis feel more inviting than intimidating. It also made me appreciate the importance of visual organisation - I continued to use tables, diagrams, and formatting tools throughout the thesis to help me process and present information in a way that works with my brain, not against it.

Writing the Synthesis

Remember that working memory challenge? Well, it's rearing its head again. The ability to read, extract, hold, manipulate and synthesise information is not something that lends well to my neurodivergence. I have spent 3 days on this so far and nothing to show for it. I took a day off and decided to come up with a new approach.

I needed that break - it prompted me to shift from a linear, high-load approach to one that better supported my cognitive profile. I began externalising the process more deliberately - using visual aids, mind maps, and voice notes to track ideas without relying on internal memory. I also broke synthesis into smaller, manageable steps, allowing me to build confidence through micro-achievements

and reduce cognitive overload. This ultimately enabled me to engage with the literature more effectively and regain a sense of momentum.

Writing the Discussion

By the time I reached the discussion chapter, I was running on caffeine, sheer stubbornness, and the growing fear of not finishing on time. But oddly, I found myself enjoying it. This section forced me to step back and actually *think* - not just report. It felt like the first time I got to interpret everything I'd worked so hard to produce. I was surprised by how naturally the theoretical integration came, and how it finally felt like my voice was leading the narrative rather than playing catch-up with the literature. That said, it was also the section where imposter syndrome came knocking loudest. Who was I to situate my humble two-factor structure within grand theoretical frameworks? But I reminded myself: this research wasn't just academic, it was personal - and I had something valid to say.

This process helped me realise the value of trusting my interpretive instincts, especially when integrating findings into broader psychological discourse. It taught me that clarity doesn't mean dumbing down - it means refining complex ideas into something coherent and meaningful. I leaned into that, ensuring the discussion stayed rooted in both empirical evidence and lived understanding. Going forward, it's shifted how I approach formulation and report writing clinically: I'm less afraid to offer a thoughtful synthesis, even when it's provisional or partial. It's about holding space for meaning, not just metrics.

Reflective Extracts: Empirical Study

Date	Title & Extract
	Item development and Thematic Synthesis I'm currently writing items based on the qualitative themes, and it's much harder than I anticipated. I keep wrestling with how to phrase things clearly without stripping away nuance. I'm drawn to expressive, almost poetic language because I want to reflect the richness of the lived experience - but that often backfires and just confuses the meaning. I'm also very aware of trying to "speak ADHD" in a way that feels authentic, without slipping into stereotype or psychobabble. This tension pushes me to prioritise clarity over cleverness. I'm simplifying items, testing phrasing with others, and trying to keep each item behaviourally grounded. I'm also leaning more on feedback from Experts by Experience to ensure the language resonates and isn't tokenistic. It's shaping how I think about accessibility in research - not just in content, but in tone..
	Data Cleaning and Participant Exclusion I'm going through the data cleaning process, and it feels brutal. Watching the participant count drop from 310 to 167 makes me feel like I've failed somehow, even though I know this is the right thing to do. There's a part of me that wants to hold onto as much data as possible just to feel like the project has "enough." But deep down I know quality matters more than quantity, and that muddy data won't serve the research - or me. This realisation grounds me. I'm choosing to set clear, consistent thresholds for exclusion based on psychometric standards, not gut instinct. I remind myself that a cleaner dataset gives me more confidence in my findings - and actually strengthens my argument. This is a lesson I'll carry into clinical work too: sometimes, letting go creates more clarity.
	Running Exploratory Factor Analysis (EFA) I'm running EFA for the first time, and I feel completely out of my depth. Despite all the time I've spent crafting this measure through a sequential exploratory design - carefully building eight themes - the analysis reduces

everything down to just *two* factors. It's disheartening. At first, I genuinely worry I've done something wrong, or that the data are rejecting the conceptual work I put into this. There's a sense of loss, almost - like the richness of what I was trying to capture has been flattened.

After speaking with my supervisor, I realise this is not only common but expected. What I interpret as a failure is actually a sign that the measure is psychometrically sound. Fewer, cleaner factors mean greater internal consistency - not less complexity, but more structure. It's a perspective shift I didn't see coming.

This experience teaches me not to cling too tightly to my initial model. I let go of the expectation that the qualitative themes would map neatly onto quantitative factors. Instead, I start viewing the two-factor structure as a strength - something more refined, not reductive. It helps me embrace the iterative nature of research and gives me confidence to move forward with interpretation. I'm learning that good research often involves grieving what you expected… and making peace with what the data are actually telling you.

Writing: Results

I'm writing up the results now, and it's oddly satisfying. There's something very grounding about translating numbers into meaning. But I catch myself trying to apologise for the findings that aren't particularly "exciting" - like I need to dress them up or justify their place. I'm learning to resist that urge.

I decide to keep the results clean, honest, and readable. I'm focusing on logical flow, clear subheadings, and integrating stats without overwhelming the reader. The writing becomes more confident when I stop trying to prove something and instead just report what's there. This mindset is helping me find my voice - not just as a researcher, but as a psychologist.