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Psychological Impact of an Adult ADHD Diagnosis

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Thesis Abstract

The study aimed to explore the processes people go through when diagnosed with ADHD in adulthood from a psychological perspective. ADHD has recently been recognised as affecting adults. Limitations exist in the breadth and depth of qualitative research into the experiences of those receiving an ADHD diagnosis in adulthood. Existing research is largely descriptive, with a prominent focus on pharmacological treatment. As such, psychological processes have not been sufficiently explored. Without ADHD-specific models of adjustment, the literature on identity, cognitive adaptation and stigma is examined.

A qualitative methodology was employed taking a critical realist perspective. A purposive sample of twelve participants was recruited through adult mental health services. Each participant took part in one digitally recorded, semi-structured interview where experiences were explored. A mixed inductive-deductive thematic analysis of the transcribed interviews was conducted following the Braun and Clarke (2006) six-stage methodological process.

Three master themes were identified with subthemes: (1) Looking back: *different, faulty; relief and regret; reframing*; (2) Looking inwards (with acceptance); and (3) Looking outwards: *labelling: disability, stigma and social comparisons*. The study highlighted participants' attempts to make sense of their past experiences considering the diagnosis, reflect on the effect the diagnosis had on their sense of self and identity and consider the positives and negatives of sharing their diagnosis. Participants also compared themselves with others and some reflected on ADHD being a shared experience within families.

The current research has highlighted the contradictory nature of the diagnosis; that an ADHD diagnosis was necessary to access support and acknowledge people's experiences (and potentially attribute past behaviours and experiences to ADHD rather than personal failure) but there remains a struggle with the sense of self, the way people are viewed by others (e.g. feeling stigmatised)

and the permanence of being or having ADHD forever. This highlights the importance of supporting people to understand their interpretation of the diagnosis and target intervention in the adjustment process. Pre- and post-diagnostic support and contact with others who have been through the process would be beneficial. The study also highlights the need for further anti-stigma campaigns.

A number of methodological limitations is discussed. Future research is necessary to explore models of attribution and interventions about the interpretation of the diagnosis and self-concept. The thesis ends with a personal reflection about my research journey and a discussion about diagnosis.

Statement of Contribution

1. Project design:
Zoe Young (with supervision from Anna Tickle and Alinda Gillott)

2. Applying for ethical approval:
Zoe Young (with supervision from Anna Tickle)

3. Recruiting participants:
Alinda Gillott

4. Data collection:
Zoe Young

5. Transcription:
Zoe Young

6. Analysis:
Zoe Young (with supervision from Anna Tickle)

7. Write-up:
Zoe Young (with supervision from Anna Tickle and comments on journal paper from Alinda Gillott and Maddie Groom)

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Journal Paper

Psychological impact of an adult ADHD diagnosis*

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Abstract

Objective: To explore the psychological impact of receiving a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in adulthood. **Method:** A qualitative study was conducted. Twelve adults (seven male, five female; aged 18-54) participated in semi-structured interviews. A thematic analysis was conducted on the data. **Results:** Three master themes were identified with subthemes: (1) Looking back: *different, faulty; relief and regret; reframing*; (2) Looking inwards (with acceptance); and (3) Looking outwards: *labelling: disability, stigma and social comparisons*. **Conclusion:** The results highlighted a dilemma: diagnosis was necessary to access appropriate support, was helpful to acknowledge people's experiences (and potentially reframe them), understand oneself better (as well as recognise strengths) and foster a sense of belonging, but there remains a struggle with the sense of self, the way people are viewed by others (e.g. feeling stigmatised) and the permanence of being or having ADHD forever.

Keywords

ADHD, qualitative study, adults, thematic analysis

*Article prepared for submission to Journal of Attention Disorders

Introduction

Attention Deficit Hyperactivity Disorder (ADHD) is described as a neuro-developmental condition that is diagnosed in 3-5% of children (NICE, 2008). The diagnostic criteria state that ADHD is characterised by poor attention, hyperactivity and impulsivity (American Psychiatric Association, 2013). Debate exists around the existence and origins of ADHD, with some arguing for ADHD being a social construct (Timimi & Taylor, 2004) and others asserting that it stems from a combination of influences: genetics, biological and psychosocial (Faraone & Biederman, 1998). Ascription to such explanations, as well as how ADHD is conceptualised, is likely to vary across countries, although there remains much to be learned about the societal and cultural context of ADHD (Asherson et al., 2012; Waite & Ivey, 2009). Most research centres on diagnosis, aetiology and medication treatment, despite NICE guidelines advocating a holistic approach to care, incorporating psychological and behavioural approaches in both children and adults (NICE, 2008).

More recently, there has been recognition that people experience symptoms of ADHD into adulthood, with 2-5% of adults meeting the diagnostic criteria (Barkley, Fischer, Smallish, & Fletcher, 2002; Kessler et al., 2006; Wilens, Faraone, & Biederman, 2004) and a recent shift has occurred towards studying adults and the lifetime course of ADHD. The continuation of ADHD symptoms into adulthood potentially has significant impact and is associated with a range of social and emotional difficulties: adults with ADHD have more road traffic accidents, higher divorce rates, more substance misuse, and change jobs more frequently than adults without ADHD (Advokat, Martino, Hill, & Gouvier, 2007; Faraone et al., 2000; Wilens et al., 2004). However, these associations are unclear and causality cannot be established. These associated difficulties are thought to have more of an impact on those who are diagnosed in adulthood, leading some to suggest that outcomes may be improved for those diagnosed earlier in life (Klein et al., 2012). However, it is unclear whether those diagnosed in adulthood also experienced symptoms in childhood and what aspect of the diagnosis may have mediated this relationship, for example, access to services or the types of intervention received.

Despite such a range of social, emotional and mental health issues (Biederman, Newcorn, & Sprich, 1991; Kessler et al., 2006; Klein et al., 2012) being linked with ADHD, there exists little qualitative research into these experiences, with most research taking a medical perspective with the aim of ascertaining cause and improving diagnosis and medication treatment. Such studies leave little scope for understanding the impact such a diagnosis may have on an individual, especially when ADHD in adulthood is only recently becoming widely recognised and is still highly stigmatised (Mueller, Fuermaier, Koerts, & Tucha, 2012).

Although ADHD is increasingly recognised by health, education and social care professionals, only recently it was relatively unknown. Consequently, many adults may have experienced difficulties throughout their lives without understanding why or seeking appropriate support. Research has indicated that ADHD may be heritable (Faraone et al., 2005), and so diagnosis of a child often leads to the recognition of ADHD symptoms in their parent(s), who may then themselves choose to seek diagnosis. However, stigma continues to surround ADHD, particularly in adults, due to public uncertainty and misunderstanding about the diagnosis, or the nature of the disorder (Kooij et al., 2010; Mueller et al., 2012) and this may limit people seeking help or accessing services and may also contribute to the impact a diagnosis has on an individual.

Few studies have considered the psychological impact of receiving a diagnosis of ADHD in adulthood. Two related qualitative studies have suggested participants and their partners went through six stages of acceptance after diagnosis: (1) relief and elation, (2) confusion and emotional turmoil, (3) anger, (4) sadness and grief, (5) anxiety, and (6) accommodation and acceptance (S. Young, Bramham, Gray, & Rose, 2008; S. Young, Gray, & Bramham, 2009). Online narratives (Fleischmann & Fleischmann, 2012) explored the impact of the diagnosis on stress, and themes emerged around the advantages of having an ADHD diagnosis and positive experiences in terms of creativity and spontaneity. The differing experiences of those diagnosed in childhood and those diagnosed in adulthood was explored by Matheson and colleagues (2013) who identified themes around accessing services, the burden of ADHD, and issues related to pharmacological treatment. Consistent with previous

research (Klein et al., 2012), adjustment was shown to be improved for those diagnosed at a younger age.

Theories around labelling are useful to draw upon (e.g. Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Being given a 'label' can lead to stigma, reluctance to disclose the diagnosis, reduced self-esteem, and reduced social contact through a process termed 'self-stigma' (Corrigan, Larson, & Ruesch, 2009). However, depending on the person, the label can also incite people to reject the associated stigma (Corrigan & Watson, 2002) or promote group cohesion between those with the same label (Watson, Corrigan, Larson, & Sells, 2007). Group membership can therefore encourage members to jointly challenge the negative consequences of their group identity, consistent with Schmitt and Branscombe's (2002) rejection-identification model. In the case of stigmatised groups, such groups provide emotional support and coping with associated stigma, especially in relation to mental health; identifying with the group enables a rejection of the negative stereotypes associated with the group, leading to a more positive view of the self and a potential impact on well-being.

Currently, specific models of adjustment to an ADHD diagnosis are under-researched and not well understood. It is therefore useful to look to other psychological models of adjustment. The notion that people receiving life-long diagnoses will pass through stages much like a bereavement (Kubler-Ross, 1970) has been criticised as this model does not allow for individual progression or reaction to a diagnosis. More recent models suggest adjustment is individual and cognitively mediated. A theory of cognitive adaptation (Taylor, 1983) was developed around adjustment response to threatening life events (such as women's experiences of breast cancer) and suggests three themes: search for meaning in the event, an attempt to gain control or mastery over the event and one's life, and efforts to enhance self-esteem often through social comparisons with others. The focal point of the model is that successful adaptation results from the ability to look at an event in a more positive light. Taylor argues that the first stage- search for meaning - primarily occurs through causal attributions. Attribution theory, originally proposed by Heider (1958) and subsequently further developed by Kelley (1971, 1973), suggests that we attribute cause to our experiences in

order to understand and control the environment around us. There are four suggested attribution dimensions: internal versus external, stable versus unstable, global versus specific, and controllable versus uncontrollable. Cognitive theories around appraisal and adaptation are useful to refer to as preliminary evidence on adult ADHD and adult Asperger syndrome diagnoses points towards re-appraisal post diagnosis (Punshon, Skirrow, & Murphy, 2009; S. Young et al., 2008).

Limitations exist in the breadth and depth of qualitative research into the experiences of receiving a diagnosis of ADHD. Existing research is largely descriptive, with a prominent focus on pharmacological treatment. As such, psychological processes have not been sufficiently explored. The purpose of the present study was to explore from a psychological perspective the processes people go through when diagnosed with ADHD. With a focus on psychological process, this study contributes to a greater understanding of how receiving an ADHD diagnosis in adulthood impacts individuals. It makes suggestions for the development of resources to inform and support clinicians and service users through this process.

Methodology

Thematic analysis (Braun & Clarke, 2006) was used because it enables searching for themes across an entire data set in a systematic and transparent fashion. The research was conducted from a critical realist epistemological position (knowledge is probable fact and a critical stance is taken to the existence of reality (McEvoy & Richards, 2006)), which holds that diagnosis is given but that there are a range of views about its 'truth' and responses to diagnosis will be individual. The data were analysed at a semantic level to enable the generation of broad themes allowing for the exploration of the meaning of an ADHD diagnosis and the experiences of those diagnosed.

It is important to acknowledge that the first author's prior experience working within services for adults diagnosed with ADHD may have influenced the aims of the research and subsequent analysis. This influence was monitored through keeping a reflexive diary, discussion in

supervision, and second coding of one transcript by the second author with no experience of practice in ADHD services.

Ethical Approval

Ethical approval was granted by an NHS Research Ethics Committee in April 2016 with a subsequent amendment approved in July 2016.

Participants and recruitment

A purposive sample of 12 adults (seven male, five female) with an ADHD diagnosis was recruited to the study from an adult ADHD clinic. The age at which the diagnosis was given varied, but all within adulthood (see Table 1). Ages at the point of interview ranged from 18 to 54 years. Time since diagnosis ranged from six months to four years and four months.

Data collection

Participants were provided with study information prior to taking part in the study. Informed consent was taken prior to interviews taking place. All interviews were conducted by ZY and were digitally recorded. Seven were conducted at a local NHS site, two at a University base and the remaining three at participants' homes. All interviews were transcribed verbatim by ZY and identifiable information was removed.

Analysis

The analysis followed the Braun and Clarke (2006) six-stage methodological process. A mixed inductive and deductive approach was employed. The analysis was data-driven without an *a priori* coding framework but was deductive or theory-driven in the sense that prior research on the impact of diagnosis was drawn upon and expectations shaped (Boyatzis, 1998).

Manual analysis began with immersion in the data via reading and re-reading the transcripts. Codes were generated by labelling the data with a short phrase or word that captures the essence of the data. Codes were then clustered together creating broader potential themes and themes were checked as to whether they existed across participants. A map of candidate

themes and collated coded data extracts was created and a central organising concept for each theme was identified. The themes were reviewed in collaboration with the second author (AT) to check that the themes adequately encompass the codes and that there is a thorough and meaningful representation of the data. Final themes were defined and named along with data extracts in order to finalise the narrative and produce the report.

Findings

Participants

12 participants (seven men, five women) were interviewed. Demographic details can be found in Table 1.

Overview of themes

Three overarching themes with sub-themes were developed through the analysis, outlining three different processes participants engaged in following diagnosis. The themes are illustrated in a thematic table (see Table 2): 'looking back', 'looking inwards (with acceptance)' and 'looking outwards'. Although the themes are presented separately, they are connected and there was no evidence that participants went through each process sequentially.

Table 1: Demographic Characteristics

	Respondents (<i>N</i> = 12)
Sex	
Male	7
Female	5
Age (at interview)	
18-24	1
25-34	2
35-44	6
45-54	3
Time since diagnosis	
0-11 months	4
1 year-1 year 11 months	4
2 years-2 years 11 months	2
3 years -3 years 11 months	1
4 years-4years 11 months	1

Table 2: Final thematic table

Overarching theme	Sub-theme
Looking back	different, faulty relief and regret reframing
Looking inwards (with acceptance)	
Looking outwards	labelling: disability, stigma social comparison

Of note, but not directly relevant to the research question, is that participants talked about the lengthy wait to access diagnostic assessment and the struggle to get a diagnosis.

Looking back

'Looking back' describes how participants looked back over their pasts (e.g. having seen themselves as different or faulty), a sense of regret over how things in their lives might have been different had they been diagnosed earlier and reframing of past experiences considering the diagnosis.

Different, faulty

All participants engaged in a process of looking back over their past experiences prior to receiving the ADHD diagnosis. Within this process, a range of views was explored with some participants who had always seen themselves as "different", "faulty", "weird", "stupid" or an "idiot", contrasting with others who expressed a sense of not feeling, or knowing they were different, believing others to be like themselves:

"I just thought I was a faulty human being and if only I could pull my socks up and try harder. That the fault must be in me as a person." (Chloe)

"I think you think that most people are like you, you don't think that you're the person that's different. You look at other people who are quiet and stuff and you think 'what's wrong with them?'" (Jen)

These contrasting views of the self can be presumed to have an impact on self-esteem as Chloe expresses an internal attribution of perceived failures and Jen clearly externalises the problem as being within others. Without an obvious reason for the differences between the two groups, it is useful to consider that such attributions may relate to the different core beliefs about the self and others that individuals may hold, based upon their learning experiences.

Relief and regret

As part of looking back, participants consistently expressed initial “relief” at being diagnosed which was often after a lengthy process where they described having to fight to get assessed. Some also expressed a desire to “roll back” due to a sense of “regret”, “anger”, “frustration” and “despair” over feeling that they had not succeeded in life or that life had always been a “struggle”. This led people to wonder how life might have been different if they had been diagnosed earlier:

“I do wonder about what would have happened - how things might have been different if I had been diagnosed as a child [...] I could have focused and been more organised and used all the strategies I am using now. Could I have done better? Would it have made any difference? Probably not! But it would make me feel better about myself. I was so cross.” (Phoebe)

This was contrasted with some participants expressing a sense of pride over the way they had dealt with things in life prior to being diagnosed:

“What the diagnosis confirmed, [was] to actually think of myself as - yes actually, not only am I not stupid but I’m actually quite brilliant to have dealt with this for so long [...] I should actually pat myself on the back. So I started to think like that.” (Russell)

¹ Some text has been removed to make extracts more manageable as indicated by [...]; this was only done when it did not alter participants’ meanings.

This sub-theme summarises a range of cognitive and emotional reactions to the diagnosis, highlighting an individual process of adjustment rather than a sequential or linear process as commonly described in physical health or bereavement literature (Kubler-Ross, 1970).

Reframing

Attributing ADHD to be a “real condition” (Russell) with a “biological” (Imran) basis allowed participants to reframe their past experiences considering the diagnosis, and take the “blame” off themselves given a “reason” for the ways in which they behave or have “struggled”:

“Actually, having a list of things that I find difficult - and now there is a reason why I find them difficult, it just makes me feel better. Yes I know I find them difficult and I know I still have to do it but I’m allowed to find it difficult – I’ve got ADHD.” (Phoebe)

Furthermore, reframing has led to an increase in self-esteem: “I feel a lot better about myself and it has increased my self-esteem and it has made me, like be able to deal with my condition better, understanding that it is real.” (Jen)

People are also looking back and feeling validated about the struggles they have faced. Petra demonstrates a shift from self-blame or an internal attribution, where not finishing university was down to “personal failure and my inability to concentrate basically”, to external attribution: “It is very validating, not just to be told you have a neurodevelopmental condition, that it is the reason for fucking up.” (Petra). Petra further described a dissonance between cognitively reframing things as not her fault but not necessarily emotionally feeling this to be the case: “I was able to mentally if not emotionally explain a lot of stuff that had happened in the past and know logically, even though it is harder to put in emotionally, that things were not my fault.” (Petra)

This contrasts with one exception where Anthony described a shift from external to internal attribution where he began to question who was to blame for relationship difficulties with friends and colleagues: “I used to think it was much more their fault but actually now I’m thinking, no probably it’s my fault.” (Anthony)

Participants therefore described an experience of letting go of self-blame to differing degrees but more commonly with a sense of a positive reframing. However, it was often coupled with a realisation of the permanence of the diagnosis: “I felt as if I have achieved something at the same time I haven’t, I have something that I have to deal with for the rest of my life” (Majeed)

However, although attributing ADHD as having a “biological” basis was helpful for some in reframing their past experiences, others expressed this negatively: “It’s not something you want to hear, that certain parts of your brain haven’t developed to the level that’s deemed normal.” (Russell). Here Russell has captured what many participants echoed by using the word “normal”, suggesting that there is a sense of being ‘abnormal’ or stigma attached to the diagnosis. This relates to the theme of ‘looking outwards’ where contrasting opinions about labelling and stigma will be presented.

Some also highlighted the limitations with reframing:

“There is stuff I can’t do and ways that my brain won’t work and whilst it is a good thing that you know it is not your fault for a certain reason, it doesn’t make it any less frustrating that it bloody happens all the time.” (Petra)

Acknowledging and understanding ADHD as something ‘real’ allowed participants to reframe their past experiences, generally leading to self-reported increased self-esteem, although a shift in attribution of blame was seen in both directions. However, some struggled with the notion of a biological basis to ADHD due to the permanence of the diagnosis.

Looking inwards (with acceptance)

Participants consistently engaged in a process of looking inwards as they began to understand, and to some degree accept, the new diagnosis and a change in identity. Some described understanding themselves better through a process of self-reflection. For many, the process of

reframing their past experiences contributed to them being able to see themselves in a more “positive light” (Phoebe) and accept themselves as they are:

“It has effectively allowed me to just be me, so I would actually say it is freeing to a great degree. Because now I can say, this is the way I am and I have to deal with that, but I am not going to be upset by it.” (Marco)

Marco described the process of accepting himself having previously been through a proactive process of exploring and reading about the diagnosis and this being a process that he judged as quick. Marco illustrates that being able to accept himself is helpful emotionally as he suggests that he was upset about the diagnosis before accepting: “I am just different, not any less and I am okay with different.” (Marco)

Self-reflection following diagnosis led some participants to wonder “who is the real me?” (Anthony). Some described an identity problem, like being two people as they tried to reconcile the different aspects of themselves following insights gained from taking ADHD medication:

“You have an identity problem, almost like someone who has been schizophrenic and is treated for schizophrenia – so who is the real me? The one on medication or the one off medication? – because in some ways they are quite different individuals and I think there are facets of the same person.” (Anthony)

Some described a loss of identity as like a grief process:

“I was quite happy at first. It wasn’t an excuse but it explained a lot - but then I did go through that sort of grief. People say it’s like a grief, don’t they - of not being the person I thought I was.” (Jen)

Contrary to this, some saw themselves as unchanged following diagnosis:

“I am still me, if that makes sense. I am the same person who walked into that room, the same person who walked out, same cells, same body, same soul, same mind, same person with the same experiences, just one more experience on top as I walked out.” (Louis)

Some participants began defining themselves by the diagnosis as they now identify as ‘ADHD’ after finding that the more they learned about ADHD the more they felt it “described” them:

“So when I read that, I was like whoa! It fits so well. The more I read the more I, there are obviously some things that don’t apply to you but the more I read it, the more I am understanding myself and more importantly, I am finding ways to address and deal with.” (Imogen)

Conversely others saw ADHD as only part of themselves: “It is not the only thing that defines me but it is a really big part of my mental construct, my world view.” (Imogen)

Some identified with the concept of neurodiversity rather than ADHD itself:

“I try and give myself more of a break now, about a lot of things and I am much more aware of my strengths and weaknesses and I feel like it’s not just that I know myself more but I care about myself a little bit more, like I am good at these things and you’re bad at these things and that’s alright because that is you and that’s part of your weird and interesting neurodiversity which is kind of cool. It feels a bit like being in a weird little club.” (Petra)

Here Petra illustrates several points regarding a change in how they see themselves in a more positive light, being kinder to themselves and with a better understanding of themselves. This point also connects with the third theme of ‘looking outwards’ as she talks about a sense of belonging to a group.

The majority of participants described a positive effect on their self-concept through a process of self-acceptance; seeing themselves in a “more positive light” resulting in them being “kinder” (Phoebe) to themselves and no longer “beating themselves up” (Imogen) as well as giving themselves permission for the ways in which they behave or the things they find difficult:

“I kind of like myself a bit more, I think and whilst I still feel bad about things in the past but now I am much more likely to give myself a break for not having done stuff, like I don’t feel really awful about falling behind at work because there is a reason for that, you know, a process. I am not building up any more hilarious mental scars or fuel against myself, you know.” (Petra)

Although having a better understanding of boundaries and limits has been helpful for many in deciding what to tackle in life, some contrasted knowing your ceiling with being worried about blaming ADHD for things or making excuses:

“Like once you know what your ceiling kind of is, it is harder for you to work - you are a lot more aware of it - whereas before, you were constantly pushing and trying to break against something.” (Louis)

However, some described a dilemma in negotiating their new identity and the meaning the diagnosis held for them: “What is caused by ADHD and what you are using ADHD as a crutch for? So an awareness of that. You don’t want to just go ‘that’s my ADHD’ - take responsibility for the stuff that you are responsible for.” (David).

Acceptance of the new identity was often related to people looking for the positives about “being ADHD” (Chloe) such as being creative, full of ideas, empathic, fun, playful, enthusiastic, being able to think on your feet, good in a crisis, perceptive and passionate:

“There are lots of things about being ADHD that I look for [...] the fact that I am spontaneous, the fact that I will still be quite young spirited even when I’m old, that I can

find the fun in things, that ideas cross pollinate because they come so thick and fast.”

(Chloe)

Accepting the new identity led some to feel a sense of belonging to an ADHD “club” (Petra) contrasting with rejection of the ‘neuro-typical’ club: “I feel stronger to just think ‘oh nuts’ to people, I have decided I can’t be in that club.” (Chloe). Others further suggested a sense of neurodiversity being “cool” and “to be neuro-typical [...] it must be a bit boring.” (Jen)

Self-reflection and looking inwards allowed participants to see themselves more positively, which helped some to accept themselves as they are. For others, there was confusion over their identity, although some were able to incorporate ADHD into their new identity. Acceptance of identity was also linked with finding the positives about ADHD and identifying with an in-group of others with ADHD, which links with the sub-theme of ‘social comparisons’.

Looking outwards

Participants looked outwards as they made decisions about sharing their diagnosis and the experience of being labelled (e.g. possible stigma) influenced these decisions. Within this theme participants engaged in social comparisons (e.g. comparing themselves to others).

Labelling: disability, stigma

Some participants described a careful decision-making process about sharing the diagnosis as they worried about others’ reactions. Despite this worry, many described the associated positives, such as gaining support at work or university, or with family and friends: “Yeah, it sort of helps communication with my parents” (Chloe) and: “My close friends have all been really positive” (Phoebe).

For many, there were also negative aspects of sharing their diagnosis. Some felt friends haven’t understood or they have felt dismissed by them and some felt work had not been supportive. People were also faced with others not believing ADHD existed as well as not being believed in terms of their personal diagnosis, which for some echoed their experiences of seeking

diagnosis (e.g. being told by GPs: “It doesn’t exist in adults” (Imran)). The experiences resulted in participants feeling stigmatised to varying levels:

“It was knowing that it was right but wishing that it wasn’t. It fit completely, but at that stage I felt a kind of a stigma towards it and I don’t know where that came from other than the fact it was classed as a disorder, an illness, or whatever, a condition and that in itself puts a stigma on it.” (Marco)

Marco described it as a “disorder” and that this led to stigma. Furthermore, some felt understanding about adults was lacking, with some believing “it’s just naughty kids” (Russell) and consequently feeling misunderstood:

“I don’t care about the general public and what people think, but even family members, even my step-daughter, who is an adult, doesn’t understand some things and it can be frustrating when people give you certain odd looks.” (Russell)

Some people found it hard to be labelled, whereas others found the label helpful and some found it both to be helpful and a hindrance at the same time; it being hard to be labelled but also welcoming the label as it was a tool to work out what to do next:

“I also know that people have a very negative view of ADHD. They’ll either apply those negative views to me - that’s how labelling works - or just think I’m just making an excuse. I don’t know. I was mixed. It felt like a blessing and a curse at the same time.” (Russell)

Some described a sense of a change in culture or attitudes over the last few years resulting in experiencing a reduction in and potentially a rejection of stigma:

“So, what I would say, what brought me out of that most, coming back to the fact I don’t really give a shit, to be quite honest with you. I don’t care about other people’s opinions,

within reason and the fact that, that's been aided by the fact that opinions have softened." (Marco)

Social comparison

Participants explored a sense of not understanding others when compared to themselves, of wondering how other people can sit down all day, why things seem easier for others, whether others try harder, why others can take longer to understand things, how others can be regimented. Such comparisons left participants with a feeling of things being unfair:

"Yes, it is unfair, but at least now I know and I don't feel like a fool when I'm putting in the same amount [of effort] and not getting the same results." (Louis)

Some suggested that the diagnosis made them less concerned about making social comparisons and trying to fit in with other people's ideals:

"If there is something I have spent my whole life trying to force myself to be like everyone else and fit in with other people's patterns and now realising certain things, I just need to work around and work to my strengths." (Imogen)

Some described a sense of belonging or "community" (Majeed) with the realisation that there are others with similar experiences to themselves leading to people joining physical or online support groups or belonging to a "weird little club" (Petra) of other people with ADHD, suggesting a sense of an in-group/out-group distinction:

"To feel this alone as well because you can see there are a whole group of people out there who have similar experiences to you and I am now involved in a few online groups [...] you can share that support and understanding, you just don't really get from anyone else." (Imogen)

Participants shared a strong sense of not being understood by others (with friends, family or at work); however, an exception to this was when ADHD was a shared experience within families. Three participants had a child or children diagnosed with ADHD, two participants suspect ADHD in their child and were seeking diagnosis and several participants also described their parents as having “undiagnosed ADHD” (Anthony) or “ADHD traits” (Imogen). There was a sense of being similar to such family members and that this was comforting, but also of things being “normal” within their family: “It was probably when people started to talk about [son’s] differences, that’s when I started to pay more attention to the fact that it [ADHD] even existed, to me he was normal because he was like me” (Jen); which may have impacted on people recognising ADHD in themselves. Also, a sense of a shared experience within families and a positive effect on parenting was expressed:

“I am looking forward to, like if [son] does have ADHD, I am looking forward to being able to parent him in a way that is accepting and acknowledging that and being able to share something with him that actually is like a different way of seeing the world.”

(Petra)

The theme of looking outwards describes sharing the diagnosis as a carefully made decision which resulted in both positives and negatives. Social comparisons were helpful but also a hindrance as they led people to realise how life was unfair compared to those without ADHD but also to recognise their strengths, foster a sense of belonging and to make links with associated support networks. Participants also reflected on the positives of ADHD being a shared family experience.

Discussion

The aim of this study was to explore the psychological processes people go through following a diagnosis of ADHD in adulthood. The impact of the diagnosis was captured by two self-reflective themes: looking back (and focussing on their past) and looking inwards (with acceptance and a focus on identity and understanding oneself); and one interpersonal theme: looking outwards (being labelled and comparing with others).

Looking back

Participants in the current study described feeling different to others or faulty, having spent a period looking back over their experiences before being diagnosed. Feeling different or faulty may reflect an ingroup/outgroup distinction (Tajfel, 1982) and participants may have experienced the negative effects of outgroup membership prior to diagnosis by way of prejudice or stigma where perceived difference may have been either the cause or result of outgroup membership. This experience of 'difference' echoes previous qualitative work on the experiences of being diagnosed with ADHD in adulthood (S. Young et al., 2008). Similarities have also been found in individuals diagnosed with Asperger syndrome in adulthood, which is of interest as a related lifelong neurodevelopmental condition (Punshon et al., 2009).

Previous literature reports a hypothesised process that people diagnosed with ADHD in adulthood go through: relief and optimism and an opportunity to reframe, moving from internal to external attribution of their difficulties, followed by emotional struggles and regret over not being diagnosed earlier and how their lives might have been different had they been diagnosed earlier. This was suggested to be followed by a realisation of the permanence of the diagnosis and eventual acceptance (S. Young et al., 2008), and is supported by research suggesting an adult ADHD diagnosis prompts positive reframing of the past (S. Young, 2005). The current study has described similar experiences by participants. However, a clear, staged process was less evident in the current sample. Further emphasis was placed on the internal reflections and the social comparisons made by participants, with a clear sense of not having fully accepted the past. The processes participants described can usefully be framed within Taylor's (1983) cognitive adaptation model, which includes three stages of adjustment following a significant event: search for meaning, attempts to gain control, and attempts to increase self-esteem.

Consistent with Young (2005), participants in the current study used cognitive coping strategies such as cognitive reappraisal or reframing. Engaging in a process of looking back and externalising their difficulties as caused by ADHD rather than because of their personality or being lazy or stupid allowed some participants to let go of perceived failures. This is consistent

with the first stage in Taylor's (1983) cognitive adaptation model (search for meaning), which, Taylor argues, primarily occurs through causal attributions (Heider, 1958; Kelley, 1971, 1973). Our propensity to place greater emphasis on internal agency over external reasons for behaviour is known as a fundamental attribution error and can be seen by participants prior to their diagnosis. In general, attributions about past failures were shown to shift from internal to external attributions in the current study, although this was not always the case and some questioned to what extent they could attribute their behaviours to ADHD or part of their personality. Participants also suggested a sense of attributions being stable (over unstable) due to the sense of permanence of the diagnosis (e.g. "This is how I am going to be for always" (Petra)). It is unclear to what extent this sense of stability or permanence might contribute to people's perceptions of control (over uncontrollable attribution); what is within their power or abilities. Those diagnosed with Asperger syndrome in adulthood have also highlighted this dissonance between positive reframing and there being no 'cure' and a sense of hopelessness (Punshon et al., 2009). Furthermore, biological attributions have been shown to reduce hope for change and increase passivity in schizophrenia diagnosis (Howe, Tickle, & Brown, 2014).

Consistent with the second stage of Taylor's (1983) theory of cognitive adaptation, participants increased their knowledge of ADHD and searched for strategies and support in order to gain control or mastery over the event and their lives. Participants expressed positive effects through the use of strategies, particularly those focussed on enhancing executive function.

Looking inwards (with acceptance)

Compared to Young and colleagues' (2007) description of participants' acceptance of the diagnosis and of themselves, the current study presented a diverse picture of participants' experiences. Acceptance of the diagnosis appeared to come relatively easily for many participants (especially after lengthy waits for diagnosis); however, self-acceptance was something not as easily achieved as people struggled with their sense of identity. Consistent with modified labelling theory (Link et al., 1989), being given a label and subsequently internalising the label and its stereotypes has led to reduced self-esteem and self-efficacy in mental health diagnoses (Corrigan et al., 2009).

Participants reflected on the diagnosis and attempted to integrate their diagnosis as well as their new-found insights (e.g. through reframing or self-reflection) with their existing view of self to varying levels of ease or success, which is a process also described in the schizophrenia literature (Estroff, 1989). Models about changes to identity (Brady & Busse, 1994; Cass, 1979) have been developed in the literature on sexuality and have been adapted for application to mental health. One model (Corrigan & Matthews, 2003) suggests a five-stage process of adopting a new identity: identity confusion; comparison; identity acceptance; immersion into the new culture; and identity synthesis. It is possible that in the current study, participants are at the stage of *identity acceptance* where they are learning to tolerate the new identity and beginning to disclose to trusted others. Some may well be in the stage of identity synthesis where the diagnosis has become an aspect of their identity.

Broad views were expressed as to the extent people identified as *being ADHD* or *having ADHD*. This refers to the *I am* nature of the diagnosis which is commonly seen in the literature on schizophrenia diagnoses and also in adults with Asperger syndrome who tend to relate to an *I am* rather than an *I have* view of their diagnosis (Punshon et al., 2009). The extent to which people identified as *being ADHD* opposed to *having ADHD* could also reflect a change in identity and impact on acceptance of the new identity.

A categorical separation of these two belief systems did not seem to encompass the complexity in which the participants described their identity. A continuum approach, which has more commonly been applied to diagnoses of personality disorders, proposes a continuum of the view of self from *self*, to *self-object*, to *object*. For some, ADHD was seen as an external *object* (for those who viewed ADHD as biological), for some as a *self-object* (for those who struggled to reconcile the different aspects of themselves), and for other participants wholly as the internal *self* (who felt that ADHD *described* them) (Kohut, 2013). The person's view of self can be applied clinically through *illness-identity statements*, to determine where people fall on this continuum, which have previously been used in schizophrenia research (Estroff, 1989).

Understanding this further could usefully inform intervention as the interaction between the person and 'disorder' is important in terms of progress (Strauss, 1989).

Consistent with Taylor's (1983) first stage of cognitive adaptation (search for meaning), acceptance of identity led some participants in the current study to recognise the relative positives of ADHD such as spontaneity and being young at heart, which has been coined 'benefit finding' and is also seen in the literature on Asperger syndrome diagnosis (Pakenham, Sofronoff, & Samios, 2004; Punshon et al., 2009). Identifying with ADHD also prompted a sense of belonging within a neuro-diverse 'club'. Acceptance of the new identity enables rejection of its' negative associations and is suggested to lead to a more positive view of the self (Schmitt & Branscombe, 2002). In the current study, affiliation with a similar group with a shared experience led to a more positive view of the self (e.g. as intelligent or capable). This is supported by people making social comparisons within similar *others* which encourages them to strive and improve themselves (Festinger, 1954) and is further supported by the third stage in Taylor's (1983) theory of cognitive adaptation (self-enhancement) where people engage in comparisons with others to increase self-esteem.

Looking outwards

Participants highlighted the contradictory nature of diagnosis: labelling was helpful in terms of access to support but unhelpful as people experienced the effects of stigma and being subject to others' perceptions of ADHD (e.g. childlike, adulterous or criminal). The potential of stigma impacted on participants' decision to share or disclose the diagnosis. This decision has also been argued to depend upon the extent to which the label is part of a person's identity and the views of the people around them (e.g. trustworthy versus discriminatory) (Corrigan & Matthews, 2003). This is consistent with Imogen, who chose not to disclose to friends due to previous discriminatory remarks about ADHD, and Anthony, who chose to disclose within his workplace of trusted colleagues.

Many people choose not to disclose, potentially having weighed up the costs (e.g. social disapproval) and potential benefits (e.g. increased wellbeing and decreased distress) of sharing

their diagnosis (Corrigan & Matthews, 2003). It has been argued that non-disclosure may be costly for the individual as secrecy may lead to preoccupation with the label (Lane & Wegner, 1995). However, out of five suggested levels of disclosure (*social avoidance, secrecy, selective disclosure, indiscriminate disclosure and broadcasting*) (Corrigan & Matthews, 2003) those in the current study most commonly engaged in selective disclosure where they shared their diagnoses with only those closest to them, although with some degree of shame remaining for some. Although disclosure had a range of positive and negative effects on people, sharing the diagnosis was experienced positively when it led to a sense of belonging to a group. Identifying with a group has been said to help group cohesion and help people to resist stigma through a sense of group identity and empowerment (Watson et al., 2007).

Along with disclosure, people made other attempts to reduce stigma; the use of less pejorative labels as a way of dealing with stigma or discrimination has been described (Corrigan & Matthews, 2003) and in this study some described themselves as “neurodiverse”. This is more commonly used within the autism literature where the neurodiversity movement calls for autism and ADHD to be seen as a natural human variation rather than a disability (Armstrong, 2010; Jaarsma & Welin, 2012), although people did think that societal attitudes about ADHD were changing, which mirrored views of those diagnosed with Asperger syndrome in adulthood (Punshon et al., 2009).

Clinical Implications

Calls have been made for earlier recognition of ADHD (e.g. Kean, 2004). Earlier identification may avoid the development of negative core beliefs (Newark & Stieglitz, 2010; Safren, Sprich, Chulvick, & Otto, 2004). This study also has a number of clinical implications where ADHD is diagnosed in adulthood.

Negative responses from others made a difference to the impact of diagnosis. Public information and de-stigmatisation by way of public awareness campaigns are emerging (e.g. Craven et al., 2015); however, the current findings highlight the need for further campaigns to reduce stigma. Anti-stigma campaigns could focus specifically on understanding ADHD in

adulthood and could focus on success stories of adults living with ADHD, highlighting potential positives and benefits in line with the literature on benefit finding (Affleck & Tennen, 1996; Sears, Stanton, & Danoff-Burg, 2003). Raising awareness and reducing stigma are also relevant within the UK healthcare system as the study highlighted a lack of understanding of ADHD in adulthood within medical practitioners, which may reflect a gulf in knowledge between child and adult services (Asherson, Chen, Craddock, & Taylor, 2007).

The importance of cognitive appraisal of the diagnosis has highlighted a key clinical implication in terms of assessing somebody's interpretation of the diagnosis (pre- and post- diagnosis). This could facilitate intervention through exploration of the event, provision of information and support to develop coping strategies (possibly through Cognitive Behavioural Therapy (CBT)) for those who find it difficult to reappraise negative attributions (Safren et al., 2004). CBT has potential additional benefits with regard ADHD symptoms (Z. Young, Moghaddam, & Tickle, 2016). However, a range of cognitive and emotional reactions was found, such as relief and regret, highlighting the need to attend to an individual's reaction to the diagnosis.

A deliberately staged process of assessment is employed in some UK healthcare services for assessment of Asperger syndrome in adults. This is a model that could usefully be applied in adult ADHD where a pre-assessment, psychologically-minded triage assessment about the potential diagnosis could facilitate preparation for possible outcomes of the diagnosis. Post-diagnostic follow-up with an emphasis on adjustment to the diagnosis and access to support and management strategies could also be beneficial, with specific guidance for staff of all professions to follow. The current study also highlights practical utility for clinical psychology as a profession in understanding the psychological processes that may be related to issues of diagnosis and identity. The study emphasises an opportunity to lead service development in terms of innovations around pre- and post-diagnostic intervention (and further research) that can be grounded in the findings of this study.

The findings suggest the need for specific testing of models of attribution in relation to diagnosis and interventions to support adjustment to diagnosis. This should be carried out through the

development and testing of screening tools relating to appraisal of the diagnosis and information giving (which could include contact with others who have previously been diagnosed and adjusted). Furthermore, research into cognitive interventions about self-concept and the interpretation of the diagnosis would be beneficial.

Limitations and Conclusion

Participants were interviewed at different time points following diagnosis, which could reflect people being at different stages in the adjustment to the diagnosis. However, the time taken to adjust is likely to be individual and there are additional benefits of variation in the sample giving a breadth of experience. Additionally, each participant was interviewed only once and retrospective accounts were relied upon. A longitudinal design where participants were interviewed at various stages in their journey could help to further our understanding of this topic. Furthermore, the time at which participants were diagnosed may have affected the impact of the diagnosis due to the social climate at the point of diagnosis where people diagnosed earlier may have experienced more stigma.

The current research has highlighted a dilemma: that receiving the diagnosis was necessary to access appropriate support, was helpful to acknowledge people's experiences (and potentially reframe them), understand oneself better (as well as recognise strengths) and foster a sense of belonging, but there remains a struggle with the sense of self, the way people are viewed by others (e.g. feeling stigmatised) and the permanence of being or having ADHD forever.

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Appendix

Interview Schedule

- 1) Housekeeping: directions to toilets and fire exits
- 2) Consent
- 3) Talk through demographics questions
- 4) Begin interview

Pre-diagnosis

- What were you like as a child / in your school years?
- Tell me about when you first heard about ADHD.
- What did you think about ADHD before diagnosis?
- What prompted you to seek advice?
- Tell me about your experiences leading up to getting diagnosed with ADHD.

Post-diagnosis

- In what way was the diagnosis shared with you?
- What effect did the diagnosis have on you?
 - What did you think? / What thoughts do you remember having?
 - How did you feel?
 - How did your body react?
 - What did you do?
- Was anything helpful about receiving the diagnosis? (if so, what?)
- Was anything unhelpful about receiving the diagnosis? (if so, what?)
- Has the diagnosis changed how you think or feel about yourself? (if so, how?)
- Which areas of your life have been affected by the diagnosis?
- Did the support available to you (if any) change the impact of receiving a diagnosis?

Closing

- Is there any topic you would like to go back to?
- Would you like to comment on the interview itself?
- Do you have any questions?

Extended Paper

1. Extended background

1.1 Attention deficit hyperactivity disorder (ADHD)

ADHD is defined in the DSM-5 as 'a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development' (DSM-5; American Psychiatric Association [APA], 2013). The DSM also states that symptoms must be present before age 12 and must be evident across at least two settings. Three subtypes of ADHD are described: inattentive-type, hyperactive/impulsive type and combined-type. ADHD has faced scepticism and controversy and debate continues as to its 'truth'. There exists a vast literature on etiology and intervention and many argue that ADHD stems from multiple causes, such as genetics, biological and psychosocial influences (Faraone, 2007; Faraone & Biederman, 1998). There are those who believe ADHD exists but believe it to be over-diagnosed – diagnosis being a subjective process for clinicians given that there is no standardised set of features to identify ADHD. Further, some argue for ADHD being medicalisation of normal childhood behaviours. Others still have argued against a categorical distinction and for a continuum approach to ADHD (Levy, Hay, McStephen, Wood, & Waldman, 1997; Lubke, Hudziak, Derks, van Bijsterveldt, & Boomsma, 2009) much like the spectrum approach in autism. Despite this ongoing debate, diagnosis of ADHD is something that people experience and are labelled with and each one of those people will have their own 'truth' about it.

1.2 Neurodiversity

The neurodiversity movement is one that calls for celebration of the natural neurological differences that exist (Jaarsma & Welin, 2012). It argues against having a standard or 'normal' brain which other brains are compared and for the brain being more akin to an ecosystem than a machine (Armstrong, 2010). The movement draws from positive psychology and argues for a focus on strength over disability. Aligned with this movement is the view that disability is socially and culturally determined and success depends on the environment matching the individual (Armstrong, 2010). Although the movement has received more

attention in the autism literature, ADHD, Tourette's and learning disabilities have also been included.

1.3 ADHD in adulthood

ADHD symptoms are now believed to persist into adulthood (Barkley, Fischer, Smallish, & Fletcher, 2002; Kessler et al., 2006; Wilens, Faraone, & Biederman, 2004) and the DSM-5 has now included examples specifically relating to adolescents and adults with ADHD (APA, 2013). Research has indicated that it is the inattention aspect of ADHD that is likely to continue into adulthood, whereas hyperactivity and impulsiveness are more likely to desist (Advokat, Martino, Hill, & Gouvier, 2007), although more recently it has been argued that this may be due to problems with the reliability of self-report measures as adults tend to under-report their symptoms on self-report scales (Kooij et al., 2008; Young, 2004). The continuation of ADHD symptoms into adulthood potentially has significant impact such as social and emotional aspects; academic, relationship, and occupational difficulties (Klein et al., 2012).

1.4 Cognitive Behavioural Therapy models

A proposed CBT model of ADHD (Safren, Sprich, Chulvick, & Otto, 2004) suggests the negative experiences of those with ADHD at a young age impact self-esteem. The difficulties experienced (e.g. functional impairments such as working memory, inhibitory control and sustained attention) can hinder adaptive coping strategies, resulting in continued difficulties. They further argue that potential history of failure or negative experiences having not been diagnosed until adulthood may affect the development of negative cognitions. Developing compensatory skills by targeting negative cognitions through CBT may have a positive effect on the associated emotional aspects of ADHD. A similar model (Newark & Stieglitz, 2010) argues for the negative experiences of living with undiagnosed ADHD leading to negative core beliefs and unhelpful coping strategies. These are useful models in framing our understanding of the impact of ADHD on beliefs and coping; however, individual differences in experience are not accounted for in such models.

1.5 Qualitative research on ADHD in adulthood

A qualitative study around experiences of diagnosis and treatment in adulthood from an Interpretative Phenomenological Analysis (IPA) approach suggested participants went through six sequential stages of acceptance after diagnosis: (1) relief and elation, (2) confusion and emotional turmoil, (3) anger, (4) sadness and grief (5) anxiety, and (6) accommodation and acceptance (Young, Bramham, Gray, & Rose, 2008). However, these stages presume a linear and common process for all. This study employed only eight participants and attempted to create a model based on these participants' experiences. However, IPA studies aim to offer insight into the quality of the experience and how a person attaches meaning to that experience rather than aiming to generate a theory (Pietkiewicz & Smith, 2014). The study also included cognitive processes such as reframing and rumination in the theme about emotional impact. In a subsequent study the participants' partners were interviewed to gain insight into their experiences of being in a relationship with someone who has experienced diagnosis (Young, Gray, & Bramham, 2009) and partners also went through an emotional adjustment to the diagnosis. Both studies also looked at the experiences of medication treatment for ADHD. Although these studies looked at adjustment to diagnosis, these studies did not explore in depth the broader psychological processes relating to receiving a diagnosis of ADHD. Broader understanding of the experience of receiving a diagnosis of ADHD could inform the process of giving this diagnosis and also interventions that may follow.

The potential impact of receiving an ADHD diagnosis in adulthood on coping with stress has been explored using pre-existing online narratives (Fleischmann & Fleischmann, 2012). Many of the narratives discussed the authors' lives prior to diagnosis compared to post-diagnosis and focussed on the advantages of having an ADHD diagnosis. The analysis of the narratives however, was largely descriptive with little depth regarding the psychological processes people went through following the diagnosis. In-depth analysis may have been restricted by the data stemming from personal online narratives, as opposed to interviews or focus groups.

Adopting a more systemic approach, an evaluation of people's experiences of ADHD and access to services and clinical care was investigated by Matheson and colleagues (2013). Five themes were identified: 'An uphill struggle: the challenge of accessing services'; 'Accumulated psychosocial burden and the impact of ADHD'; 'Weighing up costs vs. benefits of ADHD pharmacological treatment'; 'Value of non-pharmacological treatment' and 'Barriers to treatment adherence'. Specific difficulties identified by participants were access to services, coping with impairment, the limited availability of psychological intervention, and inconsistent medication monitoring. A detailed analysis of the experiences with regard to healthcare professionals and medication treatment was presented. However, less emphasis was placed on the psychological impact of the diagnosis itself.

Qualitative studies are emerging exploring the experiences of adults in late life. Studies have suggested that the effects of ADHD continue to be experienced into late life, with participants describing ADHD to have had a negative effect on their career, finances and relationships, for example (Brod, Schmitt, Goodwin, Hodgkins, & Niebler, 2012). The specific experiences of women have been explored, with themes around relationships emerging as well as a focus on feeling different and experiencing rejection (Henry & Hill Jones, 2011). Furthermore, the experiences of older adults with symptoms of ADHD (although undiagnosed) found themes around feeling misunderstood and having low self-esteem (Michielsen et al., 2015). These are potentially people that have experienced the symptoms of ADHD throughout their lives but have not sought diagnosis.

1.6 Cognitive adaptations

The notion that people receiving life-long diagnoses will pass through stages much like a bereavement (Kubler-Ross, 1970) has been criticised as this model does not allow for individual progression or reaction to a diagnosis. More recent models suggest adjustment is individual and cognitively mediated: Lazarus and Folkman (1984) describe a stress and coping theory of cognitive appraisal, in which the chosen coping strategies (cognitive and behavioural ways to manage demands including problem-focussed coping

and emotion-focussed coping) are influenced by coping resources (stable personal and environmental characteristics) and the interpretation of the event (assessing how threatening or challenging it is) (Lazarus & Folkman, 1984).

'Benefit finding' (beliefs about the consequences of the event) and 'benefit reminding' (coping strategies) are adaptive coping responses to stressful events (Affleck & Tennen, 1996). Evidence of this cognitive adaptation has been reported in the physical health literature (e.g. breast cancer (Sears, Stanton, & Danoff-Burg, 2003) and HIV (McCausland & Pakenham, 2003)). Benefit finding has been shown to be related to social support use and problem-solving coping. Benefit finding themes have been found around personal growth, change in personality, increased understanding of others, building new relationships, consolidating existing relationships, change in priorities and goals, and feeling of achievement and self-satisfaction (McCausland & Pakenham, 2003). It has further been suggested that the maintenance of self-esteem is dependent on benefit finding following a traumatic event (Taylor, 1983; Taylor & Armor, 1996). Looking for the advantages of ADHD has been reported in the qualitative literature on adults (Fleischmann & Fleischmann, 2012).

1.7 Identity theories

Bem's (1972) self-perception theory states that we learn our own internal states, emotions and attitudes by observing our overt behaviours much like how we observe others' behaviours. The convergence of the views of others and our own self-perception is known as the correspondence view where the contrast of others is necessary to create a concept of the self. Our view of self can be fluid depending on the environment and the audience. This is an alternative to cognitive dissonance theory (Festinger 1957) where people struggle to hold in mind two opposing cognitions which is resolved by altering one of the cognitions.

Mental health experiences and their effect on identity have been researched and although often negative, some have found positive effects on identity by way of growth (Corrigan & Matthews, 2003). Some have drawn on models of

identity from the sexuality literature as a useful comparison with a significant change in identity. Integrating a new identity into the self-concept has been proposed to go through five stages: identity confusion; identity comparison; identity acceptance; immersion into the new culture; and identity synthesis (Corrigan & Matthews, 2003). Although parallels can be drawn, the experience of being diagnosed (i.e. someone else informing you of a challenge to your identity) may well lead to a different experience to that of adjusting to sexual identity.

1.8 Social identity and intergroup relations

Social identity theory originated by describing group processes, relations between groups and the self (Tajfel, 1959) and was further developed to explain discrimination and prejudice (Tajfel, 1969, 1970; Tajfel & Turner, 1979). Social identity theory describes the knowledge that someone is a member of a social group and this defines a person's sense of 'self' and can lead to solidarity with the ingroup and discrimination against the outgroup (Hogg, 2006). The aim of this process is positive self-esteem and self-enhancement and occurs via four principles: social categorisation; social comparison; social identity; and self-esteem. We group or categorise people to make social interactions easier, which triggers social comparison with other groups by evaluating other groups against our own. This process is based on Festinger's (1954) social comparison theory, where we compare our opinions and abilities with others if there is no objective comparison to measure against. The outcomes of these comparisons are important for self-esteem and social identity. Social identity theory therefore proposes that group membership and comparisons are motivated by self-esteem and positive self-image, which can be achieved by positive evaluation of one's group.

Being part of a group that is stable and meaningful can enhance our psychological well-being therefore well-being can be impacted if our social identity is challenged. Such a challenge, loss or change to our social group requires a period of adjustment, whether such a change is perceived favourably or unfavourably (Haslam, Jetten, Postmes, & Haslam, 2009). How permeable the boundaries to social groups are perceived to be will affect the

extent to which the individual ascribes to the role of that group. This results in distancing from the less desirable group, rejecting the negative stereotypes associated with the group or trying to improve the group's situation (Haslam et al., 2009). Group membership therefore encourages members to jointly challenge the negative consequences of their group identity as per Schmitt and Branscombe's (2002) rejection-identification model. In the case of stigmatised groups, such groups provide emotional support and coping with associated stigma, especially in relation to mental health; identifying with the group enables a rejection of the negative stereotypes associated with the group, leading to a more positive view of the self and a potential impact on well-being. Support groups may be well placed to offer such support, a valuable resource where services for adults with ADHD are scarce.

1.9 Labelling and stigma

Scheff's (1966, 1974) conceptualisation of labelling theory regards mental illness as a result of society's reaction to norm breaking from culturally defined stereotypes. This approach has been widely criticised for a number of reasons: its lack of empirical evidence, its etiological hypothesis and its limited recognition of the negative effects of labels in relation to stigma (Link, 1987). Link and colleagues' modified approach to labelling theory (Link, Cullen, Struening, Shrout, & Dohrenwend, 1989) asserts the importance of the negative effects labelling can have on an individual with a mental health difficulty. The extent to which people diagnosed with a mental health difficulty expect people to discriminate against them or reject them impacts their desire to socialise with others. This results in three possible outcomes: not disclosing the diagnosis, avoiding potential rejection from others by avoiding social contact or improving the awareness of others about the particular label (Link et al., 1989). However, it has been suggested that people can also choose to reject the negative associations that others hold (Rüsch, Angermeyer, & Corrigan, 2005).

Labelling in itself does not create stigma but in addition to stereotypes and prejudice, and social and economic circumstances can create stigma. Additionally, a power imbalance is also necessary as the stigmatised group is

one of lesser power. Public stigma is therefore the combination of stereotypes, prejudice and discrimination in the context of power differences (Corrigan, 2000; Link & Phelan, 2001). The power imbalance is particularly pertinent for ADHD as healthcare professionals are in a position of power as gatekeepers of referral for assessment in an area that is particularly underserved (Matheson et al., 2013). Self-stigma by contrast is the combination of stereotypes, prejudice and discrimination (Corrigan, 2000; Link & Phelan, 2001) and is where we turn negative attitudes on ourselves as members of the stigmatised group. Fear of stigma is a known barrier to accessing mental health services (Rüsch et al., 2005).

A further area of stigma comes with structural discrimination where resources for certain groups of people are withheld or restricted whether purposefully or not (Corrigan, Markowitz, & Watson, 2004). Again, this is particularly relevant to the services available for adults seeking ADHD assessment or treatment, as nationally these services are lacking and the care received will vary depending upon the available services in the area in which someone lives (Kooij et al., 2010).

It is useful again to draw on the sexuality literature in relation to disclosure of mental health labels as there may be parallels with the costs and benefits of disclosure (Corrigan & Matthews, 2003). Benefits of disclosure include positive impact on well-being, increased self-esteem, decreased distress (from withholding the information) and potential benefit to interpersonal relations. This may be particularly relevant in ADHD as understanding someone's behaviour (e.g. interrupting or not concentrating) in light of ADHD may foster understanding and it can be useful for giving support in the workplace. However, there are also costs of disclosure such as social disapproval and social avoidance (Corrigan & Matthews, 2003).

Disclosure also breaks the 'secrecy cycle' where keeping the label a secret can encourage pre-occupation with the label (Lane & Wegner, 1995). Five levels of disclosure (Corrigan & Matthews, 2003) have been proposed: social avoidance (where people only associate with others with a similar label for

example); secret (where people keep the label a secret but don't avoid others); selective disclosure (where people only disclose to those closest but shame may still remain); indiscriminate disclosure (where there is no secrecy); and broadcasting (where people disclose to educate others and can give a sense of power over the diagnosis). Further research is needed to understand the conditions in which each level of disclosure occurs.

Stigma and its impact in ADHD is not as yet well researched, although people have been found to negatively evaluate people displaying ADHD-type behaviours in very brief interactions (Canu & Carlson, 2003) and based solely upon a diagnostic label of ADHD (Canu, Newman, Morrow, & Pope, 2008) and have shown increased peer rejection and hostility towards people in videos (Paulson, Buermeyer, & Nelson-Gray, 2005). Further social issues that may give rise to stigma relating to ADHD are a lack of understanding as to the etiology of ADHD and the ongoing debate about ADHD and medication regarding controlled substances and fears over abuse or addiction (Bussing et al., 2012; Stockl, Hughes, Jarrar, Secnik, & Perwien, 2003). A further factor specific to ADHD is that mental health difficulties that are easily concealed are hypothesised to suffer less stigmatisation (Canu et al., 2008); however, for some, ADHD-type behaviours can be easily recognisable, which may result in stigma being more likely.

In developing an adolescent ADHD stigma questionnaire (Kellison, Bussing, Bell, & Garvan, 2010), the main constructs around stigma were disclosure concerns, negative self-image and concern with public attitudes. Also, based on their findings, the authors suggest that as concerns about public perceptions and disclosure rise, so does self-stigma (Kellison et al., 2010). Furthermore, stigma has been shown to impact access to mental health services in ADHD (Kooij et al., 2010). One recent review concluded that significant stigma towards those with ADHD exists across the lifespan (Lebowitz, 2016).

2. Extended methodology

2.1 Qualitative Methodology

Qualitative methodology focuses on people's experiences and the sense that they make of their lives, and usually employs text rather than numerical data. Participants are selected purposively consistent with the phenomena being explored rather than for being representative (Carter & Little, 2007). There exist different approaches to qualitative methodology, all of which share the broad aim of describing, analysing and interpreting social phenomena. Rich, in-depth data is collected and given priority. Context is highly important and the researcher should be immersed in the data in order to fully explore the phenomenon in its context. Researcher reflexivity is crucial in qualitative methodologies as the researcher must acknowledge their own influence on the research and the interaction between the researcher and the participants, especially as the researcher is the main research tool. The exploratory nature of qualitative research is in contrast with quantitative approaches which aim to test predetermined hypotheses (Holloway & Wheeler, 2013).

Quantitative research has been criticised for context stripping and generalisability has been criticised to only exist in contexts that are very similar to the original research. Qualitative research can usefully answer this critique by adding contextual information to the data gathered (Guba & Lincoln, 1994; Lincoln, Lynham, & Guba, 2011). Qualitative methodologies are therefore well positioned to explore human experience in populations and contexts where the research field is scant. Qualitative research allows for pre-existing theory to shape the research framework but also has the flexibility to inductively allow the data to drive the research (Holloway & Wheeler, 2013). Qualitative methodology is well placed for use in the current study as it can provide a rich insight into the participant's experiences in a field that has previously been dominated by quantitative empirical research.

2.2 Epistemology

Epistemology is concerned with the study of knowledge and the relationship between the researcher and participant and the relationship between what can

be known and the knower (Guba & Lincoln, 1994) and epistemological assumptions are concerned with what is possible to know and how data relates to the world around us. Ontology is concerned with the nature of reality or what exists and what is understood about the nature of reality constrains the epistemology (Harper, 2012). Epistemology and ontology therefore inform the appropriate methodology that can be used to find out what there is to know (Guba & Lincoln, 1994).

Individuals ascribe to the following paradigms which can be understood as a set of beliefs or world view and the individual's place in the world (Guba & Lincoln, 1994). These paradigms can helpfully be understood on a spectrum of knowledge (epistemology) from positivist to constructivist and in terms of reality (ontology) from realism to relativism: from positivism (and objective reality) through postpositivism (an imperfect objective reality), critical theory (socially and historically created structures viewed as if real) to constructivism (multiple and amendable social realities) (Harper, 2012).

The positivist paradigm is reductionist and deterministic and has dominated the sciences for hundreds of years. Positivists believe that findings are true and the corresponding ontology is realism or naïve realism where reality is assumed to exist and the corresponding epistemology is dualist and objectivist. In research, the researcher and participant are assumed to exist separately, therefore the researcher attempts not to influence the research, trying to reduce bias. Findings are replicable and seen as "true" or "fact" and hypotheses exist to be tested and verified. The aims of positivism are to predict and control and the investigator is seen as the expert (Guba & Lincoln, 1994).

Postpositivism has existed in the last few decades and differs from positivism in that it attempts to falsify hypotheses. This paradigm is consistent with positivist beliefs but answers some of the critiques. The related ontology is critical realism where reality exists. However, a critical stance to reality is taken whereby it is constrained by human flaws (McEvoy & Richards, 2006). Modified dualist/objectivist epistemology is adopted where objectivity is an aim. Findings are assessed based on whether they fit with existing evidence or knowledge

and findings are seen as probably true but are open to being falsified. Consistent with positivism, postpositivism aims to predict and control and the investigator is seen as the expert.

Critical theory sees knowledge as constructed over time where reality exists, having been shaped by social, cultural, political values. Over time these values have been reified and are now seen as real. The related ontology is historical realism and the epistemology is transactional and subjectivist. The researcher and participant are interlinked, therefore knowledge exists in the interaction between the researcher and researched. The aim of investigation is to critique and transform social structures and in doing so, the researcher is seen as the facilitator of this process (Abbass & Town, 2013).

Constructivism or social constructionism sees reality as socially constructed within a context and is therefore changeable. The associated ontology is relativist and the epistemology is transactional and subjectivist. The researcher and researched interact to create the findings within the investigation. The aim of research is to reach understanding and consensus whilst remaining open to new interpretations, which are continually revised. The researcher is seen both as a participant and a facilitator (Willig, 2013).

Epistemology informs the aims and the methodology employed in the research. It is also important for reflection over the role of the researcher and the values and beliefs that may influence the research. The researcher therefore adopted the epistemological position of critical realist as diagnosis of ADHD is something that happens to people or that people are given but there is a range of views about its 'truth' and the way people experience being given the diagnosis is individual. The aim of critical realism is to develop deeper insight and understanding (as opposed to generalisability) and is therefore consistent with the research aims in understanding the meaning of the diagnosis and the experiences of those diagnosed (McEvoy & Richards, 2006).

The researcher's prior experiences of working with adults with ADHD shaped the research design, which is consistent with a critical realist epistemology.

Based on prior clinical experience and literature, the researcher therefore made assumptions that understanding ADHD as a neurodevelopmental condition would have an impact on self-esteem. The researcher also wondered whether participants would go through a process of acceptance consistent with previous literature on ADHD and other life-long diagnoses. In acknowledging these prior experiences it was important to remain reflexive in the way the data was read and interpreted and to avoid seeking out potential themes. A reflexive diary was kept in order to foster awareness of such processes.

2.3 Qualitative approaches considered

Thematic Analysis

Thematic analysis is a method of identifying and analysing patterns in qualitative data via searching for themes or patterns across the entire data set in a systematic and transparent fashion. It searches for detailed interpretations of phenomena and is focussed on meaning. Thematic analysis is consistent with research questions about understanding people's experiences, can be used to analyse interview data, works with small data sets and fits with a range of epistemological positions (Braun & Clarke, 2006). Themes can be generated via manifest (a specific mention) or latent (reference to a concept) content, therefore implicit and explicit in content. Themes can either be inductively or deductively generated by examining the data in its raw form or expanding on or replicating existing research, respectively. Themes can also be generated by taking a combined inductive-deductive approach (Joffe, 2012).

Although thematic analysis has faced criticism for being a technique employed by multiple qualitative methodologies (Holloway & Todres, 2003), it is increasingly viewed as a stand-alone method which allows for systematic and transparent in-depth exploration of data (Braun & Clarke, 2006). Thematic analysis has also been criticised for being 'unsophisticated'. However, critics often confuse theoretical flexibility with lacking theory. Furthermore, unlike other qualitative methodologies, thematic analysis is a method not a methodology as its framework specifies analysis only and not data collection (Braun, Clarke, & Terry, 2014).

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is an idiographic approach interested in people's experiences and how they make sense of them, with a distinct focus on meaning and process. The method generally uses first-person accounts which are detailed and reflective and give voice to the participants. The researcher's aim is then to interpret the data from a psychological perspective (Larkin & Thompson, 2012). IPA has its origins in the philosophical study of being (phenomenology) and in particular draws upon hermeneutic phenomenology (interpretation). Both thematic analysis and IPA identify patterns in the data; however, the analysis in IPA is more in-depth and meaning focussed and takes a step-wise approach in analysing participants' data one-by-one (Larkin & Thompson, 2012). Although the topic is of importance to the participants and they have experiential experience (consistent with IPA research), IPA was not chosen due primarily to its focus on meaning and its idiographic nature not being consistent with the aims of the current study.

Grounded Theory

The aim of grounded theory is to develop a theory or general conclusion via inductively driven research by identifying categories within the data. It can be employed with research questions that focus on meaning and process (Charmaz, 2006). As a methodology it is epistemologically varied, bridging the spectrum from positivist to postpositivist to constructionist. Grounded theory is explicit in the methods and strategies employed and usually uses textual data. Data collection and analysis are concurrent and all elements of data are constantly checked and compared with each other (Tweed & Charmaz, 2012). Grounded theory is similar in process to thematic analysis in that they are both systematic yet flexible, but differs in the final stage of theory development, which is not precluded from thematic analysis but is not a primary aim. Grounded theory was not the chosen methodology as the current study did not aim to create a theory about impact of or adjustment to an ADHD diagnosis. The aim instead was to explore people's individual experiences and search for shared patterns.

Discourse Analysis

Discourse analysis is concerned with the study of language, as a means of constructing reality via spoken or written language. Language is analysed within interactions and in context, paying attention to variance in accounts. Discourse analysis is epistemologically connected with social constructionism where reality is constructed through social practices and interpersonal processes (Georgaca & Avdi, 2012). Discourse analysis was not selected for the current study, which is not interested in the language used to construct meaning around receiving a diagnosis. The present study in contrast focussed on describing how people think, feel and behave following diagnosis.

Approach adopted for the current study

Alongside being in keeping with the researcher's epistemological stance of critical realist, thematic analysis is consistent with the study exploring the experiences of people diagnosed with ADHD where the views about the 'truth' of diagnosis and people's experiences in receiving a diagnosis will be individual. Thematic analysis is a methodology that allows for both a deductive and inductive approach allowing for the research framework to be influenced by existing theory but remain open and remaining true to the data. Thematic analysis allowed for exploration of the impact following a diagnosis rather than being concerned with sense making, which would be more consistent with IPA. The research aimed to describe, understand and interpret people's experiences through the lens of existing theory (or use theory to deepen the interpretation of the data); it did not aim to generate new theory in this area. The Braun and Clarke (2006) approach was adopted in order to have a systematic and transparent approach to analysis of the data, which answers some of the critiques about thematic analysis being 'unsophisticated'. This approach also benefits from acknowledging the importance of reflexivity.

2.4 Participants and recruitment strategy

Inclusion criteria

Broad inclusion criteria were employed to enable recruitment of a range of participants. The criteria were: 1) be aged 18 and over; 2) have the ability to give informed consent; 3) be able to engage in a verbal interview; 4) be under

the care of the participating NHS Trust; 5) have a diagnosis of ADHD given in adulthood (18 years plus); and 6) be English speaking in order to facilitate understanding between the interviewer and participant.

Sample size

This research study uses qualitative methods, so a statistical calculation of sample size was not appropriate. A total of up to 15 participants will provide enough data for a thematic analysis of the interviews to be conducted. This is consistent with other studies using thematic analysis and research suggesting that approximately 12 participants are sufficient to identify key themes. Recruitment ended after 12 interviews were completed as it was deemed thematic saturation had occurred (O'Reilly & Parker, 2012).

Participants

A purposive sample of 12 adults with an ADHD diagnosis was recruited to the study (seven male, five female). All participants shared the experiences of receiving a diagnosis in adulthood. The age at which the diagnosis was given varied. Ages at the point of interview ranged from 18-24 years to 45-54 years. Time since diagnosis ranged from six months to four years and four months. All participants were recruited via an adult ADHD clinic, therefore diagnostic labels were verified. 20 were approached, 14 consented and a total of 12 completed the interview.

Recruitment

Stage one: Ethical agreement for the study and for recruitment via a local NHS Trust was gained from an NHS Research Ethics Committee. The clinical lead for the study (AG) was employed at a clinic for adults with ADHD and led recruitment. Participants were initially approached by AG as their clinician (or by the clinician responsible for their care who then introduced the participant to AG). AG then provided potential participants with a participant information sheet and described the study. Participants then consented to be contacted by ZY, who then arranged a time and date to meet and took informed consent prior to the interview. Recruitment posters (Appendix J) were made available in the

waiting room of the clinic which included ZY's contact details; however, no-one made contact in this way.

Stage two: To maximise recruitment, an amendment was sought from the research ethics committee to expand recruitment to a further local NHS clinic which took on long-term medication monitoring for many patients originally under the care of the ADHD clinic. Consent to be contacted by AG was sought by the team manager at the clinic. AG then made contact with potential participants and the same process as above was followed.

In total, twenty potential participants were approached to take part in the study; 14 consented and a total of 12 completed the interview.

2.5 Data collection

Demographic information

Collection of demographic information was viewed as asking for only necessary or justifiable information and also to reduce the likelihood that participants could be identifiable (Harper, 2012). Basic demographic information is useful to give context to the data and was gathered by way of a questionnaire (Appendix M) which was given to participants just prior to the interview. Justification for requesting this data is as follows: gender identity - allows for gender composition of the participants and potentially gender related differences; age range - allows for age composition of the participants to be known; and the time that had elapsed since diagnosis - to indicate how long participants had known about the diagnosis.

Semi-structured interviews

All interviews were semi-structured and conducted face-to-face. Semi-structured interviews allow for consistency between the topic areas that are approached across participants but are flexible enough to allow the interview to follow the lead of the participants (Willig, 2013). An interview schedule was designed based on current literature. Feedback on the interview questions was provided by a service user who was diagnosed with ADHD in adulthood. A pilot interview was also conducted. The interview schedule (Appendix N) was

comprised of 12 questions designed to explore participants' recollections of their experiences pre- and post-diagnosis and was flexibly followed. Prompts were used to encourage participants to elaborate on responses. Participants were also given the opportunity to add any further comments that they felt were relevant and hadn't yet been covered. Interviews took place between July and October 2016. The length of interviews ranged from 28 to 72 minutes.

2.6 Ethical considerations

Informed consent

Prior to giving informed consent, all participants were provided with a participant information sheet which explained the purpose of the study, that the study was voluntary, informed of their right to withdraw and confidentiality and anonymity explained. Participants were given the opportunity to ask questions. Consent was gained for audio recording the interviews and it was also explained that anonymous quotes may be used in the final report and appropriate consent gained. Participants' right to withdraw was explained and it was explained that two weeks following the interview any data may still be used. Participants were offered a £10 shopping voucher to thank them for their time. It was explained that they would receive this whether they finished the interview or not. Cost of travel was reimbursed where required. Two copies of the consent form were made; one was given to the participant and one was kept for study records.

Interviewing

Participants were offered the choice over the time, data and location of their interview. Participants were told that they could choose whether they wished to answer each question and that the interview could be paused or ended at any point.

Confidentiality and anonymity

Interview transcripts were anonymised, had identifiable information removed (locations and names of services) and pseudonyms were used for names.

Storage of information

All research data was securely stored and identifiable information was stored separately. Only the primary researcher had access to the data. According to data storage protocol, the data will be kept for seven years at the University of Nottingham, after which it will be destroyed.

Participant distress

A mock interview was conducted with an adult service user with ADHD (identified by AG) to feed back opinions on: whether the interview questions were understandable, the length of the interview and ability to concentrate, timings of the interviews and breaks. Interview questions were given to participants in advance to allow them to decide if there were any questions they did not wish to answer. Participants were informed that follow-up questions may be asked. The interviewer (ZY) has experience of working therapeutically with adults with ADHD and mental health problems and closely monitored each participant's well being throughout the interview. On the occasions that participants became upset, the discussions were paused so that the participant could take a break. It was offered for participants to end the interview but no-one took this offer. All participants were debriefed after the interview had finished and no participants reported feeling distressed. Contact details for the researcher were given should participants have any further questions. All participants were given the option of receiving a copy of the study report, which all participants accepted.

2.7 Analysis

The analysis followed the Braun and Clarke (2006) six-stage methodological process (see Table 3).

Phases of analysis

Phase 1: Familiarisation with the data began before analysis by the researcher conducting the interviews and was followed by transcribing the interviews, which some view as an important initial stage in the analysis (Bird, 2005). Interviews were transcribed verbatim with the inclusion of relevant non-verbal signs of emotions such as laughing or finding something upsetting. The

researcher then continued the familiarisation process by repeated re-reading of the transcripts and again listening to the interviews with the aim of becoming immersed in the data. Throughout this process the researcher wrote notes of ideas of interest and salient topics that arose which were related to the research question as well as any reflections in their reflexive diary.

Table 3: Phases of thematic analysis

	Phase	Description of the process
1	Familiarising yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2	Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3	Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4	Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5	Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6	Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

(Braun & Clarke 2006, p. 87)

Phase 2: The aim of coding is to organise or group the data prior to the development of themes. The researcher therefore coded each transcript in its

entirety except for on occasions when sections of the transcripts were not related to the research question in any way. Codes were applied sentence by sentence and the researcher was careful to keep contextual data within the codes where possible. For an example of a coded transcript see Appendix O.

Phase 3: Each transcript was colour coded to allow the codes to be easily linked back to their original transcript prior to codes being transferred to a spreadsheet where they could be grouped together (Appendix P). Codes were initially grouped together under the headings of emerging theme ideas that had become apparent during the previous phases of analysis. The aim of this stage was to begin creating broader themes. Once the codes had been organised into initial theme ideas, the first and second authors reviewed the emerging themes and further refined them by redistributing the codes accordingly. After a further stage of refinement, only the relevant themes and their respective codes were transferred to an additional spreadsheet where further refinement could take place. Codes that did not bear relation to any of the emerging themes were discarded; however, the researcher was careful to ensure content that diverted from or contradicted the emerging dominant ideas was retained.

Phase 4: It was at this stage that the researcher went back to the original data and re-read the coded data extracts that had been housed by the various themes and sub-themes to check whether the themes describe the data and whether there is a clear pattern. Post-it notes were then used to decide how best to organise and group the themes and sub-themes in a way that best told the narrative of the data and a thematic map was created (Appendix Q). The researcher then went back to the original data and listened once again to the interviews to check that the themes reflect the data. It was at this stage that the researcher reviewed the themes by way of a saliency analysis where each theme was reviewed in terms of its recurrence and importance; as recurrence alone is not equivalent to importance (Buetow, 2010). For example, this analysis highlighted that the time taken to get a diagnosis was a theme that was salient, in that it recurred, but was not important in that despite it framing participants' experiences prior to diagnosis it did not directly answer the research question.

Phase 5: The next process was further refinement of the themes and some re-grouping of sub themes led to a final thematic table (Appendix R). A final check was made to ensure the themes were internally consistent, coherent and distinctive (Braun & Clarke, 2006) and to check that all the codes could be housed within the themes. Once the thematic table was finalised, the themes were defined to describe what each theme entailed and why the data within that theme was of interest. Themes were then given names as a summary of the story that each theme told.

Phase 6: The final stage began with writing up the results section of the report in order to tell the story of the data using interesting extracts and going beyond description to build an argument that answered the research question. This process involved interpretation of the data and led to framing the data within the context of previous literature.

2.8 Quality assurance

It has been argued that qualitative research should be subject to a certain degree of quality appraisal. However, quality frameworks or checklists that are commonly used in quantitative research do not map on well to qualitative data and are often not consistent with the epistemological assumptions of the research. Following quality guidelines or principles is a more relevant approach to adhering to the assessment of research quality (Spencer & Ritchie, 2012). In terms of guiding principles, to ensure that the analysis was rigorous, the process was determined by and checked against the Braun and Clarke (2006) checklist of what constitutes a good quality thematic analysis. Furthermore, two important areas of quality assurance are discussed.

Credibility - Credibility in qualitative research refers to being transparent about how the findings were reached and the defensibility of the findings (Spencer & Ritchie, 2012). To this end the process of analysis has been presented at various points in the appendices, including extracts of raw data and the process has been discussed as above (section 2.7). Credibility checks were also employed at the level of coding where the first and second authors joint coded

an interview transcript. Furthermore, the second author (AT) had no prior experience of working within ADHD services, which allowed for a further stage of quality assurance in terms of ensuring interpretations were driven by the data rather than experience.

Rigour - To ensure and evidence methodological rigour, the researcher aimed to be transparent with the decision making process, for example giving a clear rationale for the methodology adopted (section 2.3) and the composition of the sample (section 2.4). Furthermore, reflexivity was highly important therefore a section on critical reflection including an extract from the researcher's reflexive journal was included (section 4.6). These quality assurance checks are consistent with the aims of the research not being replication, objectivity or consistency (Spencer & Ritchie, 2012).

3. Extended findings

3.1 Overview of themes

Participants looked back over their past experiences (e.g. having seen themselves as different or faulty). They expressed a sense of relief then regret over how things in their lives might have been different had they been diagnosed earlier. Participants reframed past experiences considering the diagnosis, often attributing their past behaviours or experiences to ADHD. Participants engaged in a process of looking inwards through self-reflection as they began to understand themselves better and to accept the new diagnosis and a change in identity to varying degrees. Participants looked outwards as they made decisions about sharing their diagnosis and the experience of being labelled (e.g. possible stigma) influenced these decisions. Furthermore, participants engaged in social comparisons (e.g. comparing themselves to others) leading to both positive and negative effects on self-esteem and reflected on ADHD being a shared experience within families.

3.2 Looking back – further exemplar quotes

Looking back refers to the diagnosis prompting participants to examine or re-examine their pasts. There are three sub-themes within this theme; 'Different, faulty', 'relief and regret' and 'reframing'.

3.2.1 Different, faulty

Having looked back over their pasts, participants reflected on a sense of feeling different or faulty: "There is something wrong, I feel like there is something different between me and other people, like how can people just sit down all day?" (Louis).

Some described the difficulties they have experienced in the past as causing them to believe that they were "stupid":

"I've started to realise that I have certain issues with remembering things: dates, places of things and just being all over the place and I thought it was me; I thought I was stupid; I can't get it together, you know, I'm just a bit stupid." (Russell)

This feeling of difference was reinforced by labels being given to participants as children, as one participant describes being called "a problem child" (Louis) and expressing that they had internalised this label having heard it so much.

Some described "feeling like a failure" (Chloe), or "feeling like an idiot" (Russell) and believing they were "weird" (Jen). This led to people to being self-critical about their perceived flaws: "I was critical and down on myself about a lot of the things that I found difficult, about how scatty I was about how disorganised, about how I was late or forget appointments" (Phoebe)

3.2.2 Relief and regret

Participants described a range of emotions that they experienced after diagnosis. Particularly pertinent was a sense of a shift from relief to anger or frustration: "Initially it was relief but that didn't last long - then it was anger,

frustration - you feel angry with yourself and you're angry with everybody else.”
(Jen)

Jen reflects on feeling angry about not being diagnosed earlier and wanting to blame others for her circumstances. David shares this sense of regret over not being diagnosed earlier:

“There are so many things that have gone by: skills you have missed, the feelings of frustration that were brought up. Okay, it's a mixed bag of emotions, like finally having a diagnosis but there was quite a bit of despair, like oh my god, why wasn't this done earlier?” (David)

David reflects on not having been diagnosed earlier as particularly frustrating as when he was struggling at school he was seen by an Educational Psychologist and ADHD was not picked up on.

Some looked back and expressed anger at the “wasted” years:

“I am very angry about the years that I wasted - getting made to feel like a loser, crazy person, trying to deal with all the other stuff that was going on and never doing any of that successfully until I got what I feel like is the sensible diagnosis for me and then I was able to start dealing with it and making progress.” (Imogen)

Here Imogen shares feeling that her life didn't get started until after being diagnosed and a sense of her achievements in life beginning after diagnosis.

Participants wondered what they could have achieved and shared a sense that things in life could have been different if they had had the right support: “I wish my intelligence was reflected in my qualifications [...] I wish I had some sort of job, career, whatever that would reflect my intelligence.” (Jen)

Jen shared a sense of not being happy with her achievements as she felt she was capable of achieving more, especially career-wise. She also felt that it was

too late to change career now and expressed a real sense of regret over not having a career that she enjoyed or that challenged her.

One participant wondered whether being diagnosed earlier or younger could have had a negative effect:

“I don’t know if I would have got the diagnosis before if it would have had a negative effect, I might have thought I can’t go uni, I’ve got ADHD, I’ll make a mess of it [...] I think for me I think it’s better that I got a diagnosis as an adult because I learnt the coping strategies before I was diagnosed with it, so I already had the mentality of no excuses, before I got the diagnosis. I think that’s one way in which it’s good to be diagnosed as an adult.” (Russell).

One participant didn’t regret not getting diagnosed in childhood, just sooner in adulthood: “It has been huge. I wouldn’t change it, the only thing I would change would be getting the diagnosis five years earlier because there are so many things that would have been different about my way forward” (Imogen).

3.2.3 Reframing

Participants highlighted that diagnosis and attributing ADHD to having a neurodevelopmental basis led them to look back over their pasts and reframe past behaviours or perceived failures as due to ADHD and not as personal failures and that this was a validating experience. Participants now had an alternative explanation for perceived shortcomings or failures resulting in a shift from self-blame (internal attribution) to ADHD being the reason (external attribution): “It is very validating, not just to be told you have a neurodevelopmental condition, that it is the reason for fucking up.” (Petra). Others felt that they now had a reason for other aspects of their lives being different: “Personal life: it explains a few things for me, in terms of the way I have acted around friends maybe, or why I feel like my social life is quite different to some of, a lot of my other friends.” (David). David reflects on him now having a reason for feeling like his social networks were limited (compared

to his peers) and that this could now be attributed to, or related to ADHD rather than a fault in himself as a person.

Reframing past experiences as due to ADHD led many to the realisation that things were not their fault:

“I couldn’t help things and actually I just work differently from other people in some ways, so that was just really huge.” (Petra)

Here Petra reflects on not only reframing her experiences as outside of her control but also acknowledging a sense of difference, although there is no indication of difference being negative here.

Louis describes no longer seeing himself as a problem child, having internalised this label that he was given when he was younger:

“It was just the emotional release of all that pent up thing, knowing what people were saying before, ‘you’re just a problem child’ [...] even though deep down you know it is not true, if people say it enough it becomes true in itself and it sticks with you. And it’s not exactly a great thing.”
(Louis)

Participants also expressed a sense of diagnosis allowing them to attribute concerns or worries about their mental health to being because of ADHD:

“It just lets you know that you’re not crazy, the diagnosis itself is like, just knowing that is like, phew! I’m not insane, there’s a reason why I’m like this. I don’t mind being like this but just that I know there is a something. I’m happy with that.” (Louis)

Louis describes the diagnosis as a relief that his difficulties were not explained by another diagnosis. He explained that going through the ADHD assessment process reassured him that a psychiatrist had assessed his mental health more

broadly and there was no other explanation for his difficulties. Louis shared a sense of ADHD being preferable to other possible diagnoses.

Reframing ADHD as “real” (Russell) was helpful: “It was some kind of biological problem that was there rather than just my mind-set that needed changing.” (Imran). This had a positive impact on self-esteem: “The majority, I feel a lot better about myself and it has increased my self-esteem and it has made me, like be able to deal with my condition better, understanding that it is real.” (Jen)

Participants described an experience of letting go of blame to varying degrees but with a sense of a positive reframing; however, it was often coupled with a realisation of the permanence of the diagnosis, which was expressed negatively with a real sense of frustration as some described diagnosis as two-fold:

“It is nice to know what’s wrong but this is a thing that is going to be wrong forever that I can’t solve.” (Petra)

The concept of permanence was something that many participants reflected upon. Some expressed a sense that prior to diagnosis they had been searching for answers and initially believed that things might improve naturally or that there may be a solution to the problems but diagnosis prompted the realisation that there is no ‘cure’ and others reflected that medication was not a panacea: “Pills don’t make skills.” (Imogen)

Although many participants were able to mentally explain the past, some expressed not fully being able to put things to rest:

“So, [diagnosis] has not necessarily allowed me to put stuff to rest, like I still feel bad about things that I have failed at in the past but then I am able to, the better bit of me is able to go it wasn’t your fault” (Petra)

Attributing behaviours to ADHD was also helpful with partners. It helped some partners to a better understanding of their difficulties which has increased support:

“It was a relief for my wife for the diagnosis. It allowed her to realise that there is something actually going on that we can target, that we can plan for, we can create strategies to deal with and it’s not just me not wanting to help or me not, intentionally forgetting to do things, not picking up the shopping or me being generally a bad person as it were.” (Marco)

3.3 Looking inwards (with acceptance) – further exemplar quotes

Looking inwards refers to participants’ beliefs about themselves and their identity and encompasses and broadly describes ‘acceptance of identity’.

Looking inwards helped some participants to learn about themselves and understand themselves better and accept themselves:

“I think being diagnosed helped me end my marriage; I was very unhappy... but I think it helped me think that life is too short; you are who you are and it helped me deal with my sexuality [...] it just gave me answers that I didn’t even know I had questions about but it answered these weird questions and then sort of like developed into me just thinking, you know what I am who I am and I want to live my life.” (Jen)

Here Jen reflects on having been in an unhappy marriage and through a process of self-reflection was able to accept facets of herself that she had not fully recognised before. She was then able to come out as gay and end her relationship. Others also described diagnosis as a “catalyst for change” (Louis) in terms of self-acceptance rather than being self-critical.

For some, the diagnosis gave them direction and led to researching ADHD, being proactive and adopting strategies:

“Now I have a diagnosis I can start dealing with things and actually just deal with it, rather than flapping around in the wind, as it were, directionless; now I have a direction, something I can deal with [...] I actually now see it as a boon, especially for what I do [for a living] - it is a

benefit, the ability to actually pick out things that other people just wash over, I find very helpful.” (Marco)

This concept of having a different and valuable skill-set was echoed by other participants who felt strengths in the work environment (that they attribute to ADHD) are beneficial, especially when working with non-ADHD colleagues: “I come up with lots of different ideas and it is the ideas that are interesting because they [colleagues] can then run with the ideas, but the idea itself is often what people struggle to come up with.” (Anthony)

Some participants reflected on how the diagnosis impacted their perception of self:

“But actually it was very positive, that the main effect was very positive because it sort of made me realise that although this is all part of my personality, there is a reason for so many of the things, and so many of the things that I have always been like.” (Phoebe)

Here Phoebe shows acceptance of ADHD into her identity.

“Being able to connect with all of those experiences and seeing that there are things that fit with your experiences, it makes you feel like you are not alone with it - you are not nuts - you are not just lazy and useless and unproductive, but you are dealing with something that is different and you are finding your way through that.” (Imogen)

Accepting the new identity also helped some participants to connect with others with a shared identity:

“[I have linked with] this whole group of people, especially at the university, that have faced adversity, that have support with this and that’s made me feel better about not having achieved what academically I’d hoped I would, because it just wasn’t there. That makes me feel like I

do belong to a group of intelligent people who do have trouble with this.”
(Chloe)

This quote reflects a sense of belonging but also a positive effect on identity as Chloe acknowledges the strengths of those with ADHD.

Others further suggested a sense of neurodiversity being “cool” (Petra) and a sense of it being “boring” (Jen) to be neuro-typical:

“Yeah, just what it is like to be neuro-typical and it must be a bit boring don’t get me wrong, I do feel for you neuros it must be really tedious! But no, I think it would be really nice just to have calm in your life, there is not a lot of calm in your life when you have ADHD.” (Jen)

The majority of participants described a positive effect on their self-concept through a process of learning about themselves and understanding themselves better, understanding their strengths and weaknesses, seeing themselves in a more positive light resulting in them being “kinder” (Phoebe) to themselves and no longer beating themselves up: “I think of myself in a more positive light, I feel like it has provided me with a language to understand why I do things in certain ways or don’t do things.” (David).

“So I am a lot kinder to myself now I think, instead of beating myself up and saying, I am just rubbish I should be able to all these simple things for goodness sake - they’re simple - you should be able to get them done. I’m kinder to myself; I feel like I understand myself better.”
(Imogen)

Having a better understanding of “strengths and weaknesses” (Majeed) or knowing your “ceiling” (Louis) led to some making different decision about what to tackle in life:

“Just knowing [about the diagnosis] is very [useful], because I have a really good awareness now of my boundaries and my limits of the stuff I

can do and stuff I can't do which is quite good, so that has been really helpful." (Petra)

Conversely, some contrasted knowing your ceiling with being worried about blaming ADHD for things or making "excuses" (Russell) and using ADHD as a "crutch" (David):

"It can give you an out, so you can start blaming it, so oh I will blame it on my ADHD, I've got ADHD, it can lead you to be lazy, that has been the case with me, again it is a double-edged sword, so you can use it as an excuse, oh I'm really tired oh it's my ADHD, that's why I can't study. That's how you can make it worse, oh I can't study now because I've got ADHD. Whereas before I could." (Louis)

It was not only participants themselves who might use ADHD as an excuse, but they also perceived others to do the same: "When he [husband] found out, then he related everything to my ADHD and so that became something to dismiss me with." (Chloe).

3.4 Looking outwards – further exemplar quotes

Looking outwards refers to the way in which participants related their diagnosis to others by sharing their diagnosis and comparing themselves to others. It includes two sub-themes: 'labelling: disability, stigma' and 'social comparison'.

3.4.1 Labelling: disability, stigma

Some participants described a careful decision-making process about sharing the diagnosis where they weighed up the costs and benefits of sharing with different people (e.g. with friends or at work). People worried about the reactions of people and when, what and why they should share. People shared their diagnosis in a variety of ways and for a variety of reasons:

"So I was relieved to get the diagnosis - I just didn't know what I should be sharing with people, and when I should share it and why should I

share it. All my colleagues know about it and they all just said, 'yeah, right, we knew!', that was helpful." (Anthony)

For Anthony, his colleagues had already considered that he might have ADHD prior to his diagnosis but this had not been discussed with him. Anthony works in mental health services and his colleagues have experience of working with ADHD. This shared knowledge and understanding was helpful for Anthony; however, concerns about being treated differently by management remained for him.

Of those participants who shared their diagnosis with others, many described the associated positives, such as gaining support at work or university or having understanding friends:

"I was able to get some support. I was able to explain to my boss, because I told her when I started the job that I was in the process of getting a diagnosis for ADHD [...] and she is quite understanding and I don't necessarily think other employers would be maybe, but that's been good, I can actually say I can't do this; I am falling behind with this and it is because of this condition and I am able to get some help with that."
(Petra)

Participants also had negative experiences of sharing with some participants having experiences where friends have not understood or they have felt dismissed. Some decided not to share their diagnosis (which could be interpreted as concealment) due to worries about perceived negative consequences. People worried about what others would think, they worried about negative consequences with employers and being judged by others, and people also had concerns about driving and about life insurance:

"Do I have to tell anybody and what are people going to think? And I do remember having an element of worry, being worried about what people would think, did I have to write it on forms and stuff?" (Phoebe)

People were faced with others not believing ADHD existed, as well as not being believed in terms of their personal diagnosis (especially due to being an adult), which for some echoed their experiences when they were seeking diagnosis and were turned away by GPs having been told: “Well that would have been diagnosed in childhood. Look how successful you have been in your life; do you really think you would have managed that if you had ADHD?” (Imogen). This led people to having to do a lot of research about ADHD: “I had to prove to the doctor in a sense that this is what I need” (Louis) in order to persuade their GP to refer them for assessment:

“I eventually [...] went to the doctor and I went armed with my NICE guidance that said adults should be considered and referred for diagnosis of ADHD [...] and by hell or high water I am going to get someone to assess me. I don’t care if the outcome is that I don’t have ADHD; I want to know.” (Imogen)

Such experiences with healthcare professionals led participants to feeling stigmatised. People also experienced stigma from the public and family members:

“Kind of like the awareness of something like ADHD, especially with adults with ADHD, is still not a great thing; so some people will, some people don’t believe ADHD exists; it’s just naughty kids; some people believe it exists but it’s just with kids. To say you’re an adult with ADHD, some people just hear ‘I’m still a child’. ‘I’m still a naughty child’ [...] A bit of stigmatisation, there is some stigma attached to it, and it’s very much attached to that old belief that it’s a thing that naughty kids have.”
(Russell)

Some chose not to share their diagnosis at work due to anticipated stigma:

“I don’t disclose it to work, at least I haven’t done; I am not trying to hide it but it is not exactly something you want to go in an interview and go ‘oh by the way...’. I don’t think it would win me any favours.” (Russell)

People expressed a dissonance over being labelled:

“Part of me was like, kind of, ‘yes there’s a name to it’ kind of thing; it’s on paper; I can say I have this thing but part of me was like I don’t want to say I have this thing. I don’t want to be labelled or seen as, I don’t want to lean on it like it’s an excuse or something.” (Russell)

Some described a sense of a change in culture or attitudes over the last few years resulting in experiencing a reduction in stigma:

“You find some things on-line that will say that it is a made up condition, stuff like that. I won’t say so much anymore; actually I would say this was 4/5 years ago because going back 4/5 years, that is the thought, but it has changed dramatically over time.” (Marco)

3.4.2 Social comparison

Participants explored a sense of not understanding others when compared to themselves, of wondering how other people can sit down all day, why things seem easier for others, whether others try harder, why others can take longer to understand things, how others can be regimented. Such comparisons left participants with a feeling of things being “unfair” (Louis) and the impact of this as negative on their view of themselves:

“You feel like you are putting in the same effort as everyone else and you’re putting in the same amount of power and resources but you don’t get the same results, that makes you feel like shit, it makes you feel bad [...] But the fact that you know you have got disadvantage in certain areas, makes you think, okay, okay, I know now that to get the same results as them I have to put a bit more in.” (Louis)

Some described a sense of belonging, with the realisation that there are others with similar experiences to themselves, leading to people joining physical or

online support groups or belonging to a “weird little club” (Petra) of other people with ADHD, suggesting a sense of an ingroup/outgroup distinction:

“To feel this alone as well because you can see there are a whole group of people out there who have similar experiences to you and I am now involved in a few online groups [...] you can share that support and understanding, you just don’t really get from anyone else.” (Imogen)

This is an example of where the analysis was more deductive than inductive. There are overlaps with acceptance of identity; however, it goes beyond the individual to the social group.

Social comparisons also led to participants no longer feeling like they have to fit into other people’s “ideals”:

“I have been kind of teaching my family how I am rather than measuring up against my sister’s [...] yard stick.” (Chloe)

4. Extended discussion

4.1 Discussion of findings in relation to past literature

Looking back

The current study took a mixed inductive-deductive approach. In the inductive approach to the interviews, similarities were found in the experiences of participants to those found in the report by Young and colleagues (2008), particularly in relation to reframing of the past. This adds to the evidence base and our understanding of the experiences of adults following diagnosis. Further comparisons can be drawn with the perspectives of partners of adults receiving an ADHD diagnosis (Young et al., 2009), where partners also described an adjustment process following diagnosis. This was apparent in the current study as participants described diagnosis as being a relief to both themselves and their partners but also contrasted with the diagnosis leading to feeling

dismissed by partners for attributing too many behaviours to ADHD.

In line with two CBT models of ADHD (Safren, Sprich, Chulvick, & Otto, 2004), which suggest living with undiagnosed ADHD can lead to negative core beliefs and unhelpful coping strategies, many participants' reports described low self-esteem and negative views of the self. Contrary to the models, some participants did develop helpful coping strategies prior to diagnosis and diagnosis reassured them of their utility which, had a positive impact on their self-reported self-esteem.

A particularly pertinent model, which was inductively found to fit after analysis of the data, was Taylor's cognitive adaptation model (Taylor, 1983). Each of the three stages of the model can be applied to the current findings: search for meaning in the event (e.g. through causal attributions); an attempt to gain control or mastery over the event and one's life (e.g. the use of strategies and learning about ADHD); and efforts to enhance self-esteem often through social comparisons with others (usually through less fortunate ingroup members (e.g. Sears et al., 2003)). Descriptions of each of these cognitive adaptations were given by participants in the current study.

In line with Lazarus and Folkman's (1984) stress and coping theory of cognitive appraisal, the current findings highlight the importance of the interpretation of the event (diagnosis) on future coping and how available resources may mediate this effect. It is suggested that those experiencing lower distress following an event are more reliant on problem-focussed coping over emotion-focussed coping (McCausland & Pakenham, 2003) and health diagnoses that need acceptance are more likely associated with emotion-focussed coping. ADHD is therefore a diagnosis that requires acceptance so may be more associated with emotion focused coping. However, planful problem solving has been shown to be problematic in coping in adults with ADHD (S. Young, 2005). Important clinical implications may therefore centre around reducing the distress, rather than the source of the stress, which is seen as unchangeable and out of the individual's control.

Looking inwards (with acceptance)

The overall focal point of Taylor's (1983) model is that successful adaptation results from seeing events in a more positive light, specifically in a search for meaning, in which the search for gains or positives within an aversive event are known as 'benefit-finding' (a belief system) and 'benefit-reminding' (an effortful coping strategy) (Affleck & Tennen, 1996). Evidence of this cognitive adaptation was found in the present study where many participants referred to improved relationships with others, positive personality changes and positive changes in terms of life plans or goals. Benefit finding has also been reported in the literature on adult Asperger syndrome diagnosis (Punshon, Skirrow, & Murphy, 2009) as well as by the parents of children diagnosed with Asperger syndrome, where increased benefit finding was linked to increased demands (Pakenham, Sofronoff, & Samios, 2004). Acknowledgement of the positive and negative effects of traumatic events is not well accounted for in bereavement models (e.g. Kubler-Ross, 1970) which tend to focus on the negative aspects. This cognitive adaptation could therefore have important clinical implications if shown to have advantages to adjustment to diagnosis.

The use of strategies, consistent with Taylor's (1983) second stage of cognitive adaptation (an attempt to gain mastery or control over the event), was pronounced in the current study. Participants cited a wide range of strategies and reflected on the diagnosis allowing them, or being necessary for them, to access services that supported them to learn these strategies. Participants did however reflect on the desire for further support that was not available within the current NHS services.

Participants struggled with the diagnosis, prompting them into self-reflection, questioning "who am I?", versus a sense of "I'm still me". Previous research found medication gave insight into how others experience the world (Young et al., 2008), which was also the case in the current study, although participants in the current study went further in describing themselves as "two people" (Anthony) and not knowing who is the real 'them', suggesting a challenge to their identity. There was a sense for some of reaching a level of acceptance

whereby they were “allowed to find [things] difficult” (Phoebe) and “allowed me to just be me” (Marco).

Looking outwards

Consistent with Taylor’s (1983) third stage of cognitive adaptation, participants engaged in social comparisons. This can be understood in terms of social comparison theory (originally proposed by Festinger, 1954) where we learn about ourselves based upon our understanding and observations of others. The motivation for such social comparisons is argued to enhance self-esteem in those facing difficult experiences or events, which it did for those in the current study who recognised their capabilities (or shared strengths) once compared with others with ADHD. However, making such social comparisons can lead to a negative view of the self, as people compare with what they are not able to do or achieve or the things they struggle with. In the current study, participants compared themselves with non-ADHD others, leaving them wondering why things were harder for them, which is supported by previous literature on adult ADHD diagnosis (Young et al., 2009).

Participants experienced stigma in different ways: from friends and family, the public and from healthcare professionals. Participants reported experiencing public stigma (or concealed their diagnosis due to fear of others’ reactions); however, less common was self-stigma, which was reported overtly by one participant. Self-stigma often takes the form of beliefs about the self as being defective (Corrigan & Watson, 2002); however, many participants appeared to shift from views about being defective, pre-diagnosis to concerns about public stigma should they share the diagnosis.

Previous literature has reported possible reasons for stigma towards adults with ADHD from clinicians; beliefs that ADHD only affects children, lack of training, and therefore understanding about ADHD and concerns about prescribing controlled medications (Kooij et al., 2010). Stigma around mental health diagnoses has often been cited as a reason for people not accessing support (Corrigan & Rüscher, 2002). In the current study, stigma did not appear to inhibit people support seeking initially; however, some were faced with

stigmatising views from healthcare professionals and this did inhibit their further support seeking. This likely relates to structural discrimination (Corrigan et al., 2004) as people described having to 'fight' for referral for assessment resulting in delays to diagnosis, likely impacted by the lack of services for adults with ADHD. What is not reflected in this study is those who have never accessed services due to stigma and have therefore not been diagnosed. Difficulties regarding access to services was further reported in previous qualitative literature (Matheson et al., 2013).

Self-stigma can lead to low-self-esteem and self-efficacy for some but can also lead to people denouncing stigma (Corrigan & Watson, 2002). This was evident in the current findings as some participants expressed not caring about others' attitudes by rejecting the negative associations (Schmitt & Branscombe, 2002), with the exception of when stigmatising attitudes were expressed by family or friends. Research indicates that people also resist stigma through a sense of group identity and empowerment (Watson, Corrigan, Larson, & Sells, 2007) and minority group identification (Schmitt & Branscombe, 2002). This was evident in the current study as people described access to support groups as empowering and the knowledge that there are others with similar difficulties as helpful. The positives of having a group to identify with has been reported in the gay and lesbian community where group identity fosters a sense of belonging where identity acceptance and synthesis occurs with immersion into the new culture (Corrigan & Matthews, 2003).

Participants described their opinions about ADHD before diagnosis (that were influenced by stereotypes such as naughty, hyperactive children), which impacted their support seeking and accessing services. Many participants felt they did not fit into these stereotypes – impacting on recognition of their difficulties, support seeking and eventual diagnosis. This is one potential reason for participants having being diagnosed in adulthood rather than childhood. Participants often described their parents as having 'ADHD traits' with ADHD being a shared experience within the family. This also meant some did not recognise their difficulties until later in life. This is a relevant

finding as some argue for later diagnosis being linked with poorer clinical outcomes (Klein et al., 2012). It is possible that poorer outcomes could be due to lack of support or treatment; however, the protective factor of having a shared understanding and experience within the family may also be important.

4.2 Limitations of the study

Although the current study has given insight into the psychological impact of receiving a diagnosis of ADHD in adulthood, it is limited by the available sample. Those interviewed sought diagnosis of their own volition possibly due to holding certain attitudes towards diagnosis and labelling itself. Therefore, opposing opinions of those who are strongly against labelling may not be presented.

Data on ethnicity was not captured in the present study as good practice in qualitative research promotes the collection of only necessary or justifiable information and aims to minimise the likelihood of participants being identifiable (Harper, 2012). In hindsight, the sample was ethnically diverse and participants did comment on culturally specific views about ADHD. Capturing this data may have allowed for analysis and interpretation of different cultural experiences and attitudes.

4.3 Clinical implications and future research

There are several clinical implications and opportunities for future research stemming from the current findings: most participants found attributing ADHD as an external problem helpful. Illness-identity statements could be used to assess where a person places themselves on a scale of internal to external attribution of their difficulties. This could usefully inform intervention from a CBT perspective should people exhibit high self-blame and cognitive restructuring could be applied. Participants also described seeing the positives as helpful; supporting people with benefit finding post-diagnosis may therefore be beneficial. Additionally, 'success stories' of people who have adjusted to their diagnosis could be shared with those who are newly diagnosed (or even pre-diagnosis) which could further help with reframing ADHD in a positive way.

The findings of the current study have highlighted the need for further anti-stigma campaigns. These should be wide-reaching and target self-stigma, public stigma and structural discrimination. Three ways of reducing stigma have been suggested: protest, education and contact (contact with or familiarity with the stigmatised group), although a combination of education and contact has been shown to be most effective at reducing stigma (Rüsch et al., 2005).

Future research should focus on testing the effects that cognitive adaptations (such as benefit finding) and other coping strategies have on supporting the adjustment process. Further research should develop and test resources or guidance for clinicians to follow when guiding a client through the diagnostic process, which would also serve to promote awareness (and education) of adult ADHD. Future research looking at the attitudes towards ADHD from different cultures could give valuable insight into culture-specific views and potential differences in the experience of stigma.

4.4 Critical reflection

Embarking on a qualitative research project was daunting as most of my research experience has been quantitative. However, having some prior experience in the subject area was comforting. This project therefore gave me a unique opportunity to develop qualitative research skills with a client group I had experience of working with. I felt that thematic analysis was a good place to start my qualitative journey, especially as there can be a smaller epistemological leap from the positivist, quantitative research I have previously worked on compared with other methodologies. This did bring up some tensions however, as when writing up I attempted (sometimes unsuccessfully) to refrain from using the positivist language that is so common in journal papers about ADHD.

Over the course of conducting the interviews I reflected on my development as a qualitative researcher. Firstly, in terms of personal reflexivity, I felt a tension about the effects my previous experience might have on the interviews and I

worried about influencing the data and I had to remind myself that I am not searching for objectivity and to maintain awareness of when my assumptions might come into play. Secondly, I was aware of the participants not only generously offering their time, but being open and willing to share their personal experiences with me and at times, although interesting, some threads were not relevant to the research aims. This brought up a tension between my roles as both a researcher and a clinician. I reflected on these issues in supervision and I became more confident to focus the interviewees specifically on the research question and as a result, I felt the interviews improved, I enjoyed them more and they began to feel more like a conversation.

During the analysis, I continually reflected on my prior assumptions and reflected on these in supervision to remain aware of how my prior experiences might be influencing the analytic process. I was aware that I could not 'switch off' my beliefs and assumptions, but being aware of them and reflecting on them was helpful. In the analysis, theme development was a particularly difficult stage. I had coded all the data and my next task was to begin grouping the codes together. The following extracts are from my reflexive diary and were made before and after a research supervision meeting and are included to show my development as a qualitative researcher:

I feel totally overwhelmed with the amount of data I have and the task of trying to organise it and trying to make sense of it. Where do I begin? I've been trying to group codes with other similar codes but there are always several different ways that the codes could be grouped. It feels like an insurmountable task. If only I had a load of numbers that I could just feed into SPSS!! (11th November 2016)

Having met with my supervisor:

This is starting to feel more achievable. Anna's advice was to focus on the research question, which sounds obvious but I feel I keep losing sight of it amongst all the data. That advice has really helped me to make decisions on how best to group, based on which best answers my aims.

Simple but very effective. (17th November 2016)

In the next stage of analysis, I considered my decision making about the importance of themes and reflected on this being subjective. I reflected on my different perspectives as a clinician but also from the discipline of clinical psychology and as a researcher. One example was the importance of the lengthy wait people experienced prior to diagnosis, and although this likely will have had some effect on the participants experiences post-diagnosis, it was not directly relevant to the research question. I found it helpful to refer to Buetow (2010) in remembering that we are searching for themes that advance our understanding and/or address problems in the real world.

The project has prompted me to reflect on diagnosis more generally. I adopted a critical realist perspective because of the tension between diagnosis being something that is given to people but is also a social construct with a range of views about its truth. I came from a background in research on ADHD in adulthood, under a team of research psychologists and psychiatrists who have been campaigning for many years to promote awareness of ADHD, its existence in adulthood and to fight against its stereotypes and I feel this rhetoric filtered into my academic writing. The current study allowed me to take a step back and reflect on the diagnosis of ADHD compared with my views about other labels in my clinical practice where I favour an individual, formulation based approach to understanding a person's difficulties. The findings have left me feeling rather disjointed as getting the diagnosis was so powerful and validating for participants despite any associated negatives. I was also surprised that more participants did not argue for ADHD to be a social construct within a society that does not accommodate difference. This felt very different to other diagnoses where the anti-psychiatry movement is stronger (e.g. psychosis). However, I do think that the current findings reflect this tension about labelling and these issues will undoubtedly influence my continued clinical practice.

I have further reflected on the ethics of ADHD diagnosis and as adults, all participants sought diagnosis of their own volition. The effort and willpower it takes to get a referral for an ADHD assessment in adulthood means that people

must be highly motivated and potentially hold certain views about diagnosis. I did not interview anyone who had rejected their diagnosis, although people did share a range of views both positive and negative about diagnosis. This led me to consider epistemological reflexivity and how the constraints of the chosen stance and methodology may have constrained or led our findings. Intrinsic in the study design was a diagnostic label which undoubtedly limited the breadth of people and experiences that might have been shared.

The notion of the diagnosis being necessary to access NHS support was clearly highlighted and something that is rooted in our current socio-political climate. However, ADHD sits within so much debate and controversy, I feel that individuals get lost as the bigger picture is debated. I do now feel proud that this project has given voice to those individuals.

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Appendices

Appendix A: Journal of Attention Disorders submission guidelines

Journal of Attention Disorders

A Journal of Theoretical and Applied Science

2015 Impact Factor: 3.384

2015 Ranking: 42/142 in Psychiatry (SCI) | 25/139 in Psychiatry (SSCI) | 12/69 in Psychology, Developmental

2016 Release of Journal Citation Reports, Source: 2015 Web of Science Data

- SUBMISSION GUIDELINES

Journal of Attention Disorders (JAD) focuses on basic and applied science concerning attention and related functions in children, adolescents, and adults. *JAD* publishes articles including, but not limited to, diagnosis, comorbidity, neuropsychological functioning, psychopharmacology, and psychosocial issues. The journal welcomes manuscripts addressing timely, notable topics in practice, policy, and theory, as well as review articles, commentaries, in-depth analyses, empirical research articles, and case presentations or program evaluations that illustrate theoretical issues or new phenomena.

Submission

Style for all submissions must follow that of the *Publication Manual of the American Psychological Association* (6th ed.). Submission to the journal implies that the manuscript has not been published elsewhere and is not in consideration by any other journal. Submission to the Applied Research section should be no more than 30 double-spaced pages, including an abstract of 150 words or less using a sectional guideline (Objective, Method, Results, and Conclusion), a brief biographical statement for each contributing author, endnotes, references, tables, and figures, all on separate pages. Author names and affiliations should appear on a separate cover page and the manuscript should be formatted for anonymous review.

Journal of Attention Disorders only accepts submissions electronically. Electronic submissions should be sent to <http://mc.manuscriptcentral.com/jad>. Submissions must be in Microsoft Word. Please ensure that tables are editable files in Word or Excel, not images. Artwork should have a resolution of 300 dpi or higher. Images are best submitted separately from the text document. Please do not embed images into your file, as embedding raster image files (photographs) in Word or similar programs automatically reduces the resolution below what is needed for quality print publication.

Featured Sections

JAD features applied research. *JAD* additionally publishes unsolicited articles in three other sections: Research Into Practice, Research Briefs, and Literature Reviews. The first, Research Into Practice, should focus on well-developed areas of research with an emphasis on application and evaluation of practice. Specifically, the goal of these submissions is to illustrate how relevant conceptual and empirical principles can be implemented in evaluating and practice. Manuscripts should present theoretically sound

and empirically documented principles and illustrate how these have been synthesized into practiced and proven interventions.

The journal is also interested in publishing articles in a Research Briefs section promoting the dissemination of new, novel, or otherwise important research information in a format that does not require extensive journal space. Research briefs should be substantially shorter than general articles: no longer than 15 pages, including tables, figures, and references. When submitting a manuscript for consideration as a research brief, the author should so stipulate and agree not to publish a more comprehensive version of the article in another source. Finally, the journal is interested in publishing literature reviews. These reviews should be no more than 50 double-spaced pages. Authors considering writing a literature review should consider contacting the editor before submission. JAD will also publish relevant letters describing interesting cases of developments in the field relative to clinical practice.

The journal also welcomes Letters to the Editor of no more than 300 words. Letters will be published at the editor's discretion. Opinion essays on relevant topics in ADHD are published by invitation only.

Authors who want to refine the use of English in their manuscripts might consider utilizing the services of SPi, a non-affiliated company that offers Professional Editing Services to authors of journal articles in the areas of science, technology, medicine, or the social sciences. SPi specializes in editing and correcting English-language manuscripts written by authors with a primary language other than English. Visit <http://www.prof-editing.com> for more information about SPi's Professional Editing Services, pricing, and turn-around times, or to obtain a free quote or submit a manuscript for language polishing.

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[This journal is a member of the Committee on Publication Ethics \(COPE\)](#)

Appendix B: REC provisional opinion letter

East of England - Cambridge East Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

18 March 2016

Dr Thomas Schroder
Associate Professor in Clinical Psychology
University of Nottingham
B12 Yang Fujia Building
University of Nottingham
Jubilee Campus
NG81BB

Dear Dr Schroder

Study title:	Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis
REC reference:	16/EE/0108
Protocol number:	16018
IRAS project ID:	192345

The Proportionate Review Sub-Committee of the East of England - Cambridge East Research Ethics Committee reviewed the above application on 15 March 2016.

Provisional opinion

The Sub-Committee would be content to give a favourable ethical opinion of the research, subject to clarification of the following issues and/or the following changes being made to the documentation for study participants:

1. The main objective of the follow-up interview should be clarified and a draft document detailing what will be included in the second interview must be provided. Clear explanation should also be given on how participants will be consented to the second interview.
2. Detail of how the interview data will be anonymised must be given.
3. Clarification on who will be undertaking the data transcription should be provided.
4. The Case Report Forms must be amended to contain only the participant's study number to protect their anonymity.

5. The Consent Form should be amended as follows:

Point 4 of the Consent Form should be split into two parts; to allow consent to take part in the study itself and also for consent for direct quotes to be used.

Provision must be given for participants to agree to be included in the second part of the interview.

6. Clarification that the student has received appropriate training in both taking consent and qualitative interview techniques; particularly interviewing ADHD patients must be provided.
7. Further information is required on what 'housekeeping' as detailed within the Draft Interview Schedule' refers to.
8. The study poster should make it clear whether participants will receive the £10 incentive for both interviews or for only the first.
9. The study poster should include the name of the ethics committee having given approval to the study. Additionally the sentence 'The study has full ethical approval' should be reworded to state 'The study has ethical approval'.
10. Detail of the University of Nottingham's lone working policy is required.

When submitting a response to the Sub-Committee, the requested information should be electronically submitted from IRAS. A step-by-step guide on submitting your response to the REC provisional opinion is available on the HRA website using the following link: <http://www.hra.nhs.uk/nhs-research-ethics-committee-rec-submitting-response-provisional-opinion/>

Please submit revised documentation where appropriate underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. You do not have to make any changes to the REC application form unless you have been specifically requested to do so by the REC.

Authority to consider your response and to confirm the final opinion on behalf of the Committee has been delegated to the Chair.

Please contact Joanne Unsworth, REC Assistant if you need any further clarification or would find it helpful to discuss the changes required with the Chair.

The Committee will confirm the final ethical opinion within 7 days of receiving a full response. A response should be submitted by no later than 17 April 2016.

Summary of discussion at the meeting

- **Social or scientific value; scientific design and conduct of the study**

The Sub-Committee queried the main objective of the follow-up interview and further commented upon there being no inclusion within the study documentation of a draft document detailing what will be included in the second interview.

- **Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity**

The Sub-Committee commented upon the application does not make it clear how the interview data will be anonymised.

The Sub-Committee agreed it is not clear who will be undertaking the data transcription.

The Sub-Committee asserted the case report forms should contain the study number only for identification purposes, agreeing it not appropriate to use initials and date of birth in addition. The Sub-Committee voiced concern that as the study will involve a maximum of fifteen participants, use of the three identifiers could lead to ease of identification.

- **Informed consent process and the adequacy and completeness of participant information**

The Sub-Committee agreed Point 4 of the Consent Form should be split into two parts; to allow consent to take part in the study itself and also for consent for direct quotes to be used.

The Sub-Committee agreed it as unclear how participants will be consented to the second interview and further asserted provision for participants to take part in the second interview should be covered in the Consent Form.

- **Suitability of the applicant and supporting staff**

The Sub-Committee sought clarification that the student has received appropriate training in both taking consent and qualitative interview techniques; particularly interviewing ADHD patients who may become distressed.

- **Suitability of supporting information**

The Sub-Committee agreed further information is required on what 'housekeeping' as detailed within the Draft Interview Schedule' refers to.

The Sub-Committee commented upon the study poster not making it clear whether participants will receive the £10 incentive for both interviews or for only the first.

The Sub-Committee agreed the study poster should include the name of the ethics committee having given approval to the study and further asserted that the sentence 'The study has full ethical approval' should be reworded to state 'The study has ethical approval'.

- **Other general comments**

The Sub-Committee asserted detail of the University of Nottingham's lone working policy is required.

Documents reviewed

The documents reviewed were:

<i>Document</i>	<i>Version</i>	<i>Date</i>	
Copies of advertisement materials for research participants [Poster_Psychological impact of an adult ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2015 University of Nottingham Liability Insurance]		21 July 2015	
Interview schedules or topic guides for participants [Draft interview schedule_Psychological impact of an ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016	
IRAS Checklist XML [Checklist_26022016]		26 February 2016	
Letter from sponsor [16018 Sponsor Letter]		15 February 2016	
Non-validated questionnaire [Demographics Questionnaire_Psychological impact of an adult ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016	
Participant consent form [CONSENT FORM_Psychological impact of an adult ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016	
Participant information sheet (PIS) [PIS_Psychological impact of an adult ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016	
REC Application Form [REC_Form_26022016]		26 February 2016	
Research protocol or project proposal [PROTOCOL_Psychological impact of an adult ADHD diagnosis_Final version 1.0 18.02.16]	1.0	18 February 2016	
Summary CV for Chief Investigator (CI) [Staff - CV Thomas Schroder 1510 IRAS Oct15 (signed)]			
Summary CV for student [CURRICULUM VITAE Zoe Young Feb 2015]			
Summary CV for supervisor (student research) [Staff - CV Anna Tickle 1512 IRAS Dec 2015 (signed)]			

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

16/EE/0108

Please quote this number on all correspondence

Yours sincerely

PP C Halliwell

Dr Rebecca Harmston
Chair

Email: NRESCommittee.EastofEngland-CambridgeEast@nhs.net

Enclosures: List of names and professions of members who took part in the review

*Copy to: Ms Angela Shone
Shirley Mitchell, Nottinghamshire Healthcare Trust*

East of England - Cambridge East Research Ethics Committee

**Attendance at PRS Sub-Committee of the REC meeting on 15 March 2016 in
correspondence**

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>	
Dr Helen Burns	Retired GP	Yes		
Dr Rebecca Harmston (Chair)	Scientific Officer	Yes		
Dr Jessica Santos	Global Compliance & Quality Director	Yes		

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>	
Ms Carolyn Halliwell	REC Manager	
Miss Joanne Unsworth	REC Manager/Assistant	

Appendix C: Researcher's response to the REC



University of Nottingham
B12 Yang Fujia Building
University of Nottingham
Jubilee Campus
NG8 1BB

8th April 2016

East of England - Cambridge East Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Dear Dr Harmston,

Study title:	Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis
REC reference:	16/EE/0108
Protocol number:	16018
IRAS project ID:	192345

Thank you for your letter dated 18th March 2016 offering a provisional opinion for the above study.

Responses to the amendments are as follows (all changes in attached study documentation are highlighted in red):

1. The main objective of the follow-up interview should be clarified and a draft document detailing what will be included in the second interview must be provided. Clear explanation should also be given on how participants will be consented to the second interview.

- (i) The main objective of the second interview is to determine if there have been any changes to the participant's experiences or adjustment over time and would be scheduled for between two and three months after the first interview. This is primarily for those participants who are interviewed within three months of diagnosis to allow for participants to process their experiences. The protocol has been updated to reflect this.
- (ii) Participants will be given the option to consent to being contacted about the second interview when they are consenting to the first interview. Participants will be asked to give consent just prior to the second interview in case they change their minds between interviews one and two. The consent form has been updated and an additional consent form has been created specifically for consenting to the second interview. The protocol has been updated to reflect this process.
- (iii) The draft interview schedule has been updated to include questions for the first and the second interview.

2. Detail of how the interview data will be anonymised must be given.

Pseudonyms will be used in relation to any names mentioned in reports or publications and replacement words will also be used to make reference to any other identifying information, such as places.

3. Clarification on who will be undertaking the data transcription should be provided.

Zoe Young as the primary researcher will undertake the data transcription and if time constraints make it necessary a professional transcription service will be employed. The nominated service, 'The Typistry' (www.thetypistry.com) will be bound by a confidentiality agreement (Confidentiality Agreement for Transcribers form has been uploaded to IRAS). The transcription service has a secure system for data transfer, access, and storage in order to maintain data confidentiality.

4. The Case Report Forms must be amended to contain only the participant's study number to protect their anonymity.

The following section has been deleted from the protocol: "The documents and database will also use their initials (of first and last names separated by a hyphen or a middle name initial when available) and date of birth (dd/mm/yy)."

5. The Consent Form should be amended as follows:

Point 4 of the Consent Form should be split into two parts; to allow consent to take part in the study itself and also for consent for direct quotes to be used.

Provision must be given for participants to agree to be included in the second part of the interview.

The consent form has been amended as suggested and an additional consent form has been created specifically for consenting to the second interview.

6. Clarification that the student has received appropriate training in both taking consent and qualitative interview techniques; particularly interviewing ADHD patients must be provided.

The student's CV has been updated to give further detail on experience and training. The student has experience of taking consent for a number of studies with NHS patients including two studies involving adults with ADHD. The student has conducted focus groups with adults with ADHD and therefore has experience of interviewing in small groups. The student has been trained in qualitative interview techniques by Dr Anna Tickle (Academic Supervisor) via qualitative research teaching on the Trent Doctorate in Clinical Psychology.

7. Further information is required on what 'housekeeping' as detailed within the Draft Interview Schedule' refers to.

Housekeeping refers to telling participants where the toilets and fire exits are if the interview is taking place in an unfamiliar building. The draft interview schedule has been updated to reflect this.

8. The study poster should make it clear whether participants will receive the £10 incentive for both interviews or for only the first.

The study poster has been updated to reflect that participants will receive the £10 incentive for the first interview and an additional £5 incentive if they take part in the second interview. The participant information sheet (PIS) has also been amended.

9. The study poster should include the name of the ethics committee having given approval to the study. Additionally the sentence 'The study has full ethical approval' should be reworded to state 'The study has ethical approval'.

The study poster has been updated.

10. Detail of the University of Nottingham's lone working policy is required.

A document detailing the University of Nottingham's lone working policy has been uploaded to IRAS.

If you require any further information please do not hesitate to contact me.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Zoe Young', written in a cursive style.

Zoe Young

Appendix D: REC favourable opinion letter



East of England - Cambridge East Research Ethics Committee

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

14 April 2016

Dr Thomas Schroder
Associate Professor in Clinical Psychology
University of Nottingham
B12 Yang Fujia Building
University of Nottingham
Jubilee Campus
NG81BB

Dear Dr Schroder

Study title:	Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis
REC reference:	16/EE/0108
Protocol number:	16018
IRAS project ID:	192345

Thank you for your letter of 13 April 2016 responding to the Proportionate Review Sub-Committee's request for changes to the documentation for the above study.

The revised documentation has been reviewed and approved by the sub-committee.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Assistant Miss Joanne Unsworth, NRESCcommittee.EastofEngland-CambridgeEast@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of

the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra_studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" above).

Approved documents

The documents reviewed and approved by the Committee are:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of advertisement materials for research participants [Poster_Psychological impact of an adult ADHD diagnosis_Final version 2.0_08.04.16]	2.0	08 April 2016
Covering letter on headed paper [REC response letter]		08 April 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2015 University of Nottingham Liability Insurance]		21 July 2015
Interview schedules or topic guides for participants [Draft interview schedule_Psychological impact of an ADHD diagnosis_Final version 2.0_08.04.16]	2.0	08 April 2016
Letter from sponsor [16018 Sponsor Letter]		15 February 2016
Non-validated questionnaire [Demographics Questionnaire_Psychological impact of an adult ADHD diagnosis_Final version 1.0_18.02.16]	1.0	18 February 2016
Other [Confidentiality Agreement for Transcribers]		
Other [University of Nottingham Lone-working Policy]		17 July 2012
Participant consent form [CONSENT FORM-Interview 1_Psychological impact of an adult ADHD diagnosis_Final version 2.0_08.04.16]	2.0	08 April 2016
Participant consent form [CONSENT FORM-Interview 2_Psychological impact of an adult ADHD diagnosis_Final version 1.0_08.04.16]	1.0	08 April 2016
Participant information sheet (PIS) [PIS_Psychological impact of an adult ADHD diagnosis_Final version 2.0_08.04.16]	2.0	08 April 2016
REC Application Form [REC_Form_26022016]		26 February 2016
Research protocol or project proposal [PROTOCOL_Psychological impact of an adult ADHD diagnosis_Final version 2.0_08.04.16]	2.0	08 April 2016
Summary CV for Chief Investigator (CI) [Staff - CV Thomas Schroder 1510 IRAS Oct15 (signed)]		
Summary CV for student [CURRICULUM VITAE Zoe Young Apr 2015]		
Summary CV for supervisor (student research) [Staff - CV Anna Tickle 1512 IRAS Dec 2015 (signed)]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of

changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance>

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

16/EE/0108

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



pp.

Dr Rebecca Harmston
Chair

Email: NRESCommittee.EastofEngland-CambridgeEast@nhs.net

Copy to:

Ms Angela Shone

Shirley Mitchell, Nottinghamshire Healthcare Trust

Appendix E: NHS R&D approval letter

positive

Nottinghamshire Healthcare 
NHS Foundation Trust

Research and Development
Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA

E-mail: shirley.mitchell@nottshc.nhs.uk

Date of NHS Permission: 11 May 2016

Miss Zoe Young
c/o DClinPsy Trent Programme
Yang Fujia Building
University of Nottingham
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Zoe

Study title: Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis
Sponsor: University of Nottingham
IRAS/REC ID: 192345/16/EE/0108
Chief Investigator: Dr Thomas Schroder

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Foundation Trust's R&D Department. The project has now been given NHS permission by:

Dr Julie Hankin: R & D Director, on behalf of Nottinghamshire Healthcare NHS Foundation Trust

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version
Advertisement material: Poster	V2.0, 08/04/16
Interview schedule	V2.0, 08/04/16
Demographics questionnaire	V1.0, 18/02/16
Consent Form – Interview 1	V2.0, 08/04/16
Consent Form – Interview 2	V1.0, 08/04/16
Participant Information Sheet	V2.0, 08/04/16
Research Protocol	V2.0, 08/04/16

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available <http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/>

The Resource, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA
Chair: Professor Dean Fathers, Chief Executive: Ruth Hawkins



INVESTORS
IN PEOPLE | Silver

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

Yours Sincerely

A handwritten signature in purple ink, appearing to read 'Shirley Mitchell'.

Shirley Mitchell
Head of Research and Innovation

cc.

Sponsor:

Appendix F: Request for REC amendment letter



University of Nottingham
B12 Yang Fujia Building
University of Nottingham
Jubilee Campus
NG8 1BB

8th July 2016

Carolyn Halliwell REC Manager
Health Research Authority
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Dear Carolyn,

Study title:	Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis
REC reference:	16/EE/0108
Protocol number:	16018
IRAS project ID:	192345

Many thanks for your favourable opinion regarding the above study.

I am writing regarding a minor amendment to this study regarding the addition of a recruitment site. Recent pressures to discharge people from the primary recruitment site xxxx have resulted in patients being moved on to secondary care more quickly. xxxx City residents tend to be transferred to the care of the xxxx Team for medication monitoring. We are therefore proposing an amendment to the study to allow participants to also be recruited from the xxxx Team in order to meet our recruitment targets in a timely manner.

All potential participants at the xxxx Team would previously have been under the care of Dr xxxx and the xxxx (participating clinic). Dr xxxx has provisionally spoken to the Team Manager, xxxx, who has agreed to recruitment from their team (letter enclosed) pending agreement from the HRA.

Please do not hesitate to contact me if you require any further information.

Yours sincerely,

Zoe Young

Appendix G: REC approval of amendment email



RE: REC Ref: 16/EE/0108 IRAS ID 192345 Minor Amendment Acknowledgement and categorisation



amendments hra (HEALTH RESEARCH AUTHORITY) <hra.amendments@nhs.net>

Reply all | ...

Thu 11/08/2016 14:25

To: CambridgeEast NRESCommittee.EastofEngland- (HEALTH RESEARCH AUTHORITY) <nrescommittee.eastofengland-cambridgeeast@nhs.net>;
Zoe Young <msxzry@nottingham.ac.uk>; Schroder Thomas
Cc: sponsor@nottingham.ac.uk;
Mitchell Shirley (NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST) <Shirley.Mitchell@nottshc.nhs.uk>

Research

Dear Zoe, Thomas and Angela,

Further to the below, I am pleased to confirm that HRA Approval has been issued for the referenced amendment, following assessment against the HRA criteria and standards.

The sponsor should now work collaboratively with participating NHS organisations in England to implement the amendment as per the below categorisation information. This email may be provided by the sponsor to participating organisations in England to evidence that the amendment has HRA Approval.

Please contact hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Yours sincerely,

HRA Amendments Team



Health Research Authority

HRA, Ground Floor, Skipton House, 80 London Road, London, SE1 6LH

E: hra.amendments@nhs.net

www.hra.nhs.uk

The HRA is keen to know your views on the service you received – our short feedback form is available [here](#)



Appendix H: NHS R&D approval of amendment email

REC Ref: 16/EE/0108 IRAS ID 192345 Minor Amendment Acknowledgement and categorisation: Continuing NHS permission for Nottinghamshire Healthc...

Microsoft Corporation [US] | <https://outlook.office.com/owa/projection.aspx>

Reply all | Delete | Junk | ...


REC Ref: 16/EE/0108 IRAS ID 192345 Minor Amendment Acknowledgement and categorisation: Continuing NHS permission for Nottinghamshire Healthcare NHS Foundation Trust


 Mitchell Shirley - Head of Research and Innovation <Shirley.Mitchell@nottshc.nhs.uk>  Reply all | ...

Wed 21/07/2016 08:59
To: 'Zoe Young' <mszry@nottingham.ac.uk>
Cc: Morton Sally <Sally.Morton@nottshc.nhs.uk>

Research

You forwarded this message on 05/08/2016 10:53

 HRA letter.docx
497 KB

 R&D service support St...
197 KB

2 attachments (594 KB) | Download all

Hi Zoe

Thank you for forwarding me the email exchange, this will suffice for service support, therefore please accept this email as acknowledgement of continuing NHS permission for Nottinghamshire Healthcare NHS Foundation Trust.

Sally, I have saved the documentation in the e-study folder, so just fyi.

BW
Shirley

Shirley Mitchell
Head of Research and Innovation
Nottinghamshire Healthcare NHS Foundation Trust
Duncan MacMillan House
Porchester Road
Mapperley
Nottingham
NG3 6AA
Mobile: 07920 454530
Telephone: 0115 9691300 ext. 11903
Email: shirley.mitchell@nottshc.nhs.uk

Appendix I: Participant Information Sheet



Participant Information Sheet (Final Version 2.0: 08.04.16)

Title of Study: Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis

Name of Researcher(s): Miss Zoe Young, Dr Anna Tickle, Dr Thomas Schroder, Dr Alinda Gillott, Dr Maddie Groom

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Attention Deficit Hyperactivity Disorder (ADHD) is a life-long condition. Receiving a diagnosis of ADHD may affect people in different ways. The purpose of the study is to explore the experiences of people who have been diagnosed with ADHD in adulthood and the impact this may have had on them.

Why have I been invited?

You are being invited to take part because you have attended the xxxx Clinic at xxxx. We are inviting 10-15 people from the clinic to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you can keep this information sheet and you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights or the care you receive.

What will happen to me if I take part?

If you agree to take part in the study you will be asked to attend either The University of Nottingham or somewhere convenient to you once, at a pre-arranged time. At your appointment you will have the chance to talk to the researcher about the study. If you are happy to take part you will be asked to sign a consent form. You will be asked to fill in a questionnaire that asks for your age, gender and the time since you were diagnosed. You will then spend up to an hour being interviewed about your experiences of receiving a diagnosis of ADHD. You will be provided with a copy of the interview questions before your appointment and you can decide if there are any questions you do not wish to answer. The interview will be audio recorded, although what you say will remain anonymous. There may also be the opportunity to take part in an optional second interview 2-3 months after the first interview to see if your feelings have changed over time. If you are taking part in a pilot interview, the data from your interview may be included in the study.

Expenses and payments

Participants will not be paid to participate in the study but will be offered an inconvenience allowance to the value of £10 in the form of a shopping voucher to acknowledge the gift of their time and experience. Participants who take part in a second interview will receive an additional £5 shopping voucher. Participants will also be reimbursed for their travel expenses (including mileage, bus or train but not taxis) should they need to travel to the interview.

What are the possible disadvantages and risks of taking part?

We do not anticipate any risks to taking part in the study. You do not have to answer any questions that you are uncomfortable with. You may take breaks from the interview and you may stop at any point. If the interview raises any concerns we can contact your clinician or signpost you to relevant support services.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this study may help the understanding of the impact of receiving an ADHD diagnosis in adulthood. It may also lead to the development of resources to support people through this process. You might find it interesting to reflect on your experiences of diagnosis.

What happens when the research study stops?

We will contact you with the results of the study if you have said you would like to be kept informed. Your name will not be mentioned in any report.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting the Patient Advice and Liaison Service (PALS): Telephone: 0800 0153367; email: PALS@nottshc.nhs.uk.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the university will have your name and address removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (address, telephone number) will be kept for up to three months after the end of the study so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other research data will be kept securely for 7 years.

After this time your data will be disposed of securely. During this [time](#) all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel relates to you or anyone else being at risk of harm, we may feel it necessary to report this to the appropriate persons. We would aim to discuss this with you before sharing information with anybody not involved in the study.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights or care being affected. If you withdraw more than a week after the [interview](#) then the information collected so far cannot be erased and this information may still be used in the project analysis.

What will happen to the results of the research study?

We will write a report about the project. All reports are written anonymously, as such your name or identifiable details will not be disclosed.

We hope that you might find the report we write interesting too. We aim to circulate the report widely and publish the findings in a psychology journal.

Who is organising and funding the research?

This research is being organised by the University of Nottingham and is being funded by the NHS as part of a Doctorate in Clinical Psychology.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by Cambridge East Research Ethics Committee.

Further information and contact details

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Appendix J: Recruitment poster



The University of
Nottingham

Do you have a diagnosis of ADHD? Would you like to take part in a research study?

We are looking for adults over the age of 18 who have received a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) after the age of 18.

We are conducting one-to-one interviews and would like to find out more about people's experience of diagnosis.

Interviews will last one hour and you will receive a £10 shopping voucher in return for your time. You may be given the option to take part in a second hour-long interview where you will receive an additional £5 shopping voucher.

If you are interested in taking part, please talk to your clinician or contact Zoe Young by email:

msxzry@nottingham.ac.uk

The study has ethical approval granted by Cambridge East Research Ethics Committee



Appendix K: Consent form Interview 1

CONSENT FORM – Interview 1 (Final Version 2.0: 08.04.16)

Title of Study: Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis

REC ref: 16/EE/0108

Name of Researcher:

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 2.0 dated 08/04/16 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.
4. I understand that the interview will be recorded.
5. I understand that anonymous direct quotes from the interview may be used in the study reports.
6. I agree to take part in the above study.
7. I agree to be contacted about a second interview.

Name of Participant Date Signature

Name of Person taking consent Date Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Appendix L: Consent form interview 2

CONSENT FORM – Interview 2 (Final Version 1.0: 08.04.16)

Title of Study: Psychological impact of an adult Attention Deficit Hyperactivity Disorder (ADHD) diagnosis

REC ref: 16/EE/0108

Name of Researcher:

Name of Participant:

Please initial box

1. I confirm that I have read and understand the information sheet version number 2.0 dated 08/04/16 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis.
3. I understand that relevant sections of my medical notes and data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.
4. I understand that the interview will be recorded.
5. I understand that anonymous direct quotes from the interview may be used in the study reports.
6. I agree to take part in the above study.

Name of Participant Date Signature

Name of Person taking consent Date Signature

3 copies: 1 for participant, 1 for the project notes and 1 for the medical notes

Appendix M: Demographics questionnaire

Demographics Questionnaire

Study title: Psychological Impact of an adult ADHD diagnosis

1. Gender identity

- Male
- Female
- Both
- Neither
- Other

2. Age

- 18 – 24
- 25 – 34
- 35 – 44
- 45 – 54
- 55 – 64
- 65+

3. Time since diagnosis.

_____ years _____ months

Thank you for your responses!

Appendix N: Interview schedule



Interview Schedule

Interview One

- 1) Housekeeping: directions to toilets and fire exists
- 2) Consent
- 3) Talk through demographics questions
- 4) Begin interview

Pre-diagnosis

- What were you like as a child / in your school years?
- Tell me about when you first heard about ADHD.
- What did you think about ADHD before diagnosis?
- What prompted you to seek advice?
- Tell me about your experiences leading up to getting diagnosed with ADHD.

Post-diagnosis

- In what way was the diagnosis shared with you?
- What effect did the diagnosis have on you?
 - What did you think? / What thoughts do you remember having?
 - How did you feel?
 - How did your body react?
 - What did you do?
- Was anything helpful about receiving the diagnosis? (if so, what?)
- Was anything unhelpful about receiving the diagnosis? (if so, what?)
- Has the diagnosis changed how you think or feel about yourself? (if so, how?)
- Which areas of your life have been affected by the diagnosis?
- Did the support available to you (if any) change the impact of receiving a diagnosis?

Closing

- Is there any topic you would like to go back to?
- Would you like to comment on the interview itself?
- Do you have any questions?

Interview Two

|

- 1) Housekeeping: directions to toilets and fire exists
- 2) Consent
- 3) Begin interview by sharing the key themes identified during the analysis of the participant's first interview followed by:
 - Have your thoughts or feelings about your diagnosis changed since our last interview? If so, how?
 - What support have you received since our last interview?
 - What support would you have liked to receive?
 - How do you feel about your diagnosis now?
 - Have any areas of your life changed since our last interview, because of your diagnosis? If so, could you tell me about them?
 - Since our last interview, what has helped you adjust to your diagnosis?
 - Have there been any changes in the way you cope/deal with problems or difficulties? If so, could you tell me about them?

Closing

- Is there any topic you would like to go back to?
- Would you like to comment on the interview itself?
- Do you have any questions?

Probes:

- Could you expand on that point?
- Can you describe in as much detail as possible...?
- What do you mean by...?
- Do you have further examples of this?
- Could you say more about that?
- Then what happened?
- You mentioned ... tell me more about that.
- You mentioned ... what was that like for you?
- You talked about ... describe that experience in as much detail as possible.
- What else happened?
- What were your feelings about that?
- It sounds like you're saying...

Appendix O: Example coded transcript

<p>1 Interview 101</p> <p>2</p> <p>3</p> <p>4</p> <p>5 Z. What were you like as a child or during your school years?</p> <p>6</p> <p>7 All my school reports always bemoaned the fact that I was a day dreamer.</p> <p>8</p> <p>9 Although not really in trouble that much myself I did tend to get everyone</p> <p>10 around me into trouble, just by messing about a lot. When they were seeing</p> <p>11 what classes you were going in you would get the test to try and see which</p> <p>12 level you would go in they would always when there was something like that</p> <p>13 the test would come out I would be in the top group but then I would get slowly</p> <p>14 bumped back and down again because either I just wasn't doing the work or..</p> <p>15 (pause) so that made my parents really frustrated with me I just kept being</p> <p>16 called lazy just being told I was going to waste my education. Eh, when I could</p> <p>17 never entertain myself I was always bored just non-stop they did use to em</p> <p>18 when I was young used to moan that I was always squirming over everything,</p> <p>19 watching TV upside down and stuff like that em but I think my Mum kinda</p> <p>20 thought it was normal because she's got a lot of the traits herself she is very –</p> <p>21 everyone says that my Mum is very very similar to the way I have been aswell.</p> <p>22 Em friend wise I have only ever had em people kinda say I am like marmite</p> <p>23 friend wise I don't have a big group of friends I've only got a small group of</p> <p>24 people that know me quite well, other than that I just used to spark either an</p> <p>25 intense like or dislike in people instantly I couldn't figure out why that was. Em,</p> <p>26 yeh I can't really think of much else....</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p> <p>31</p> <p>32</p> <p>33</p> <p>34</p> <p>35</p> <p>36</p> <p>37</p> <p>38</p> <p>39</p> <p>40</p> <p>41</p> <p>42</p> <p>43</p> <p>44</p> <p>45</p> <p>46</p> <p>47 Z. Tell me about when you first heard about ADHD.</p> <p>48</p> <p>49 Well when I was at school it wasn't something that was ever talked about it was</p> <p>50 something I became aware of quite some time after I left and even then I didn't</p> <p>51 think it was anything to do with me I just thought it was just the way I was</p> <p>52 because either way from the moment I heard about it I always had it as a really</p> <p>53 loud hyperactive kid whose eh essentially out of control, when looking back</p> <p>54</p> <p>55</p> <p>56</p> <p>57</p> <p>58</p>	<p>School reports = daydreamer</p> <p>Bemoaned by teachers</p> <p>Not in trouble myself.</p> <p>Got everyone into trouble.</p> <p>Messing about a lot.</p> <p>Came out top in class level tests.</p> <p>Slowly bumped down levels.</p> <p>Not doing the work.</p> <p>Made parents frustrated.</p> <p>Called lazy.</p> <p>Told I would waste education.</p> <p>Could never entertain self.</p> <p>Always bored.</p> <p>Moaned I was squirming.</p> <p>Watched TV upside down.</p> <p>Mum thought it was normal.</p> <p>Mum has the traits.</p> <p>Similar to mum.</p> <p>Like marmite as a friend.</p> <p>Not big group of friends.</p> <p>Small group of people know me quite well.</p> <p>Spark an intense like or dislike.</p> <p>Couldn't understand people's responses.</p> <p>ADHD not talked about at school.</p> <p>Became aware sometime after school.</p> <p>Did not think ADHD was to do with me.</p> <p>Just the way I was.</p>
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<p>59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118</p>	<p>there was a few people who I remember I thought they may have hinted that. But people just described them as troubled kids. It probably wasn't until I was in my twenties that I really heard about it. Z. What prompted you to seek advice? As in for myself? Z. Yeah Well I think really I didn't even put it together, what it was I went to the Doctors when I think it was just over a year ago it would have been January 2015 and I said it is getting ridiculous now because I am getting to like 37 the rest of my friends now who I was always cleverer than at school had now gone on to progressing with their careers and I am still kind of left behind because I can't concentrate I can't stick with anything it is essentially like I've got a concrete weight holding me down when there is something I have to do but I can't be bothered with that and they said depression I said if it is it has been life-long... so they tried me on all these different drugs they sent me for em what's it called CBT is it? When I was there the person who I was going through that with said are you sure that it is depression you sound more like people who have attention deficit disorder. Then they talked me through it and they gave me a test to do. I went through that and I came out quite high on that and I took it back to my doctor and they said "it doesn't exist in adults". So em (Z. was that your GP?) yes she said I could write to the Local mental health team, she did do and they wrote back saying it just sounds like depression try a new drug. I then off my own back went online and found a quite a really thorough diagnostic test I forget what it is called but it was pages and pages long and goes over all parts of your life I got my Mum and my girlfriend to go through it with me and then I took that to my doctors and she wrote to them again and they agreed to see me and when I went I saw not the main, I can't remember, it was one of his.. the main guy Dr Richard there and it was somebody working beneath him there. They thought – they said to me I don't know if it exists in adults or not but even it did I don't think they would do anything about it</p>	<p>Always had it without knowing. Really loud hyperactive kid. Essentially out of control. Some people hinted. Kids w/ADHD = troubled. 20s – really heard about it. I didn't put it together. Went to the doctors. It was getting ridiculous. Getting to 37. Less clever friends progressing. I am left behind. Can't concentrate. Can't stick with anything. Like a concrete weight holding me down. Can't be bothered. Dr. said depression. Been life long. Dr. tried me on drugs. Sent me for CBT. CB therapist queried ADHD. CB therapist talked to me about it. CB therapist gave me a test. ADHD test came out high. Went back to Dr. Dr. denied adult ADHD. Referred to mental health team. MH team said depression. MH team said try a new drug. I researched ADHD online. I did diagnostic test online. Thorough diagnostic test. Got mum and girlfriend to go through test too. Took test to GP. GP wrote to MH team.</p>
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<p>119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178</p>	<p>anyway. Then she said I will just go and check with Dr Richard and then she came out and said "oh actually they do treat it". I gave them the form and then that went they wrote to Marjorie I think and she agreed to see me. I went for a diagnostic check there and she confirmed what it came out as before.</p> <p>Z. So going back to thing that sparked seeking advice....</p> <p>Yes I said at the time I was diagnosed it was the thing that made me start to do something was that I couldn't blame it on being immature anymore it was getting to the point that I was getting towards 40 and nothing is changing at all and the consequences of it now are a lot more severe than they were that then, back then it didn't have that many implications now it is getting to the point that everything I do is going to have some kind of monetary implication or implication on other people and because I really annoyed em when I first started going out with my girlfriend and went out with her work mates and all of them fell out from us instantly (07.36 I think this is what he said) apparently she goes I don't know what you managed to do but you managed to annoy everybody and all of her normal friends as well and I don't know why and she said I don't particularly understand why. Em but some of my friends as well one of them since he met his now wife has cut me off because he knows it is just too risky to have me around. Yeh but</p> <p>Z. Do you know any more about that?</p> <p>Why they said that, well apparently I do have a problem where I'll, I don't have, I'll say something before thinking about what I have said and also I can't quite, I haven't got the part of my brain that seems to differentiate between, you can be absolutely normal talking with your friends but then you've got to totally change how you are when you're around other people as well and it never seem to work for me. So it is either just sit there and be totally quiet or annoy people.</p>	<p>Saw a Dr. in MH team.</p> <p>Jnr. Dr. in MH team questioned existence of adult ADHD. Jnr. Dr. did not think adult ADHD would be treated. Jnr. Dr. found it is treated. Wrote to Consultant Psychologist. Consultant psychologist diagnosed.</p> <p>Age led to seeking diagnosis.</p> <p>Could not blame it on being immature. Towards 40 nothing changing. ADHD consequences more severe now. ADHD when older = more implications. Monetary implications. Implications for others. Really annoyed others. Fell out with girlfriend's workmates. Girlfriend said I annoyed workmates and friends. Did not understand why others annoyed.</p> <p>Annoyed some of my friends. Friend cut me off. Too risky to have me around.</p> <p>Others say I have a problem: Speak before thinking. Can't differentiate between talking to friends and others. I haven't got the part of my brain. Couldn't change how I talk to others (non-friends).</p>
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<p>179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229</p>	<p>Z. So those kind of things sparked you going to the doctor it seems like a long process (Um) and then actually getting the diagnosis Was that with Marjorie? (yes) How was it shared with you?</p> <p>After the reading I had done before going there I did kind of expect it I em started reading bits and pieces about it and then as soon as I actually got an appointment at the clinic things seem to move a bit quicker. Em but em sorry I forgot where I was then. (Z. Marjorie shared it with you) Yes and went through the bits that I clearly struggle with, like the executive function of the brain and stuff like that and I had my family there because I she had to ask them how I was as well. But I was kind of expecting it at that point em I didn't see it as anything negative really (Z. How did you see it?) Well I saw it as em a way to try and actually resolve or try and claw back a bit of what I should have actually done eh she said treatment for it can be effective so I thought obviously it's going to be beneficial in that way because it can't be any worse than how it was.</p> <p>Z. Do you remember what kind of things went through your head when you got the diagnosis?</p> <p>I was a bit annoyed that I hadn't looked into it earlier really em I felt I had been just struggling on for years em and like I say career wise I am not really gone anywhere I have just kind of been stuck in the same career... and struggling because I just can't bring myself to do all the organisational bits of it I have made daft mistakes and I have been warned about my daft mistakes but because nobody at work knows about this, they say, all my reports say I am capable of far more than what I am doing and I could have gone quite far in the company but they say I'm either not bothered about doing any it and again they started saying I am lazy while I'm doing it and I am just careless because they said I'm bored all the time. (Z. It sounds a bit like the story you heard at school) Yeh.</p>	<p>Either be quiet or annoy people.</p> <p>Expected diagnosis based on own reading. CP went through struggles. Executive functioning = struggle. Family involved in diagnosis.</p> <p>Did not see diagnosis as negative. Diagnosis = way to resolve.</p> <p>Diagnosis = claw back</p> <p>CP said treatment can be effective. Beneficial. Can't get any worse.</p> <p>Annoyed not looked into diagnosis sooner. Struggling for years Not gone anywhere career wise. Stuck in same career. Struggle with organisational work. Make daft mistakes. Reports = far more capable than doing. Could have gone far at work. Reports = not bothered, lazy, careless, bored all the time.</p>
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<p>230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289</p>	<p>Z. Getting that diagnosis did it bring up any emotions any feelings at that time?</p> <p>Em I would say it was a relief that I'd actually could put a reason down to why it was and it wasn't just that.. it was something that was probably out of my control it wasn't just me being lazy it wasn't me just being careless because I did start to wonder if maybe everyone just tries harder than me and I just can't do it. Em but there was another part of me that was just annoyed that I hadn't thought about it earlier and another part of me just thought at least it is a step on the road to trying to sort it out.</p> <p>Z. So what did you do after getting the diagnosis?</p> <p>Marjorie wrote to the Local Mental Health team about starting me on a medication and then we started booking in sessions to em actually with Marjorie partly talking about how I felt about things and the things that I struggle with ways I can get around the struggles and just things I can do myself like writing things down on a board (<i>points to white board in kitchen</i>). (Z. was there anything else helpful about those sessions?) It helped me like I say organise stuff, there things that are obvious which I never really thought about like I am always forgetting my pass when I go to work so I am always having to get temporary ones just like putting it in the same place every night say with my keys so when I go in the morning I'm not going to go without it. Little things like that that which I just wouldn't have thought about anyway even though it is really obvious just one of those things I just wouldn't have really.</p> <p>Z. So was there anything helpful about receiving the diagnosis?</p> <p>It gave me a little bit of reassurance that if something did come up at work where they were saying that my performance was not particularly good or whatever or if I was threatened with some kind of disciplinary action there was actually a reason for it and I could actually get some kind of em allowances for</p>	<p>Diagnosis = relief. Diagnosis = out of my control Not me being lazy or careless</p> <p>Wondered if others try harder I just can't do it Annoyed I didn't think about ADHD earlier A step on the road to sorting it out.</p> <p>CP instructed MH team to start medication Started CP sessions Talked to CP about struggles and solutions Solutions = write on white board</p> <p>CP helped to organise Solutions I didn't think of Always forgetting my work pass CP told me to put pass in same place every night Don't forget pass in morning Obvious solutions I hadn't thought of.</p>
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<p>290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349</p>	<p>it but I haven't got round to telling anyone as I am just trying to deal with it at this point.</p> <p>Z. Was there anything unhelpful about receiving the diagnosis?</p> <p>I guess in a way it's em, I was a little bit wary about having to rely partly on medication that concerned me a bit and it was not something that I would be a 100% be able to just change without medication it was some kind of biological problem that was there rather than just my mind set that needed changing. (Z. anything else unhelpful?) No I don't think so it is better that I knew and it was a relief that I actually did get diagnosed because it was looking when I did my research online there seemed to be a lot of frustrated people who couldn't get a diagnosis in the first place and they just kinda felt helpless and a bit lost really. (Z. yep it can be a long process cant it) Umm</p> <p>Z. So what areas of your life do you think have been affected by the diagnosis?</p> <p>Obviously my education didn't go anywhere as near as high what I could have done, I dropped out of university after getting to the first exam and being told that I hadn't actually even enrolled because on the first day I just decided to go home cus I couldn't be bothered waiting. Workwise I just kind of flittered... it's really... I won't say its ruined, it's affected my relationship with my dad because he kept saying I was lazy all the time, he made me go to work with him, he was a builder and he would just find me off somewhere messing about, he would send me to go and pick something up in the van and then he would expect me to be twenty minutes and I would be an hour and a half – 2 hours I would just decide to go home for a bit yeh so he kind of fell out with me over that and that has never really recovered. When I told him about this he just kind of dismissed it and didn't believe a word of it really. Workwise I have never really been able to go very far, I mean interviews I only got through the interview to get to work in my current place, not my current job but my current place because the first</p>	<p>Diagnosis gave reassurance. Performance not good. Threatened with disciplinary. A reason for it. Work make allowances. Haven't told anyone at work about diagnosis yet. Trying to deal with it myself first.</p> <p>Wary about medication. ADHD = not something I can 100% change without medication. ADHD = biological problem. Not my mind set that needs changing</p> <p>Better that I knew. Relief to get diagnosed. Online research = frustrated people. Others couldn't get diagnosed. Others helpless.</p> <p>Education not as high. Dropped out of uni after 1st exam. Told hadn't enrolled at uni. Bored waiting to enrol at uni. Flitted between jobs. Diagnosis affected relationship with dad. Dad made me work with him as builder. Dad said lazy. Always messing about.</p> <p>Take too long to do tasks.</p> <p>Go home whilst at work. Fell out with dad. Relationship with dad never recovered.</p>
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<p>350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 406 408 409</p>	<p>person turned the job down and then it was between me and a partially sighted women for filing job so I was kind of, I was the only viable alternative. All my other interviews before hand had been absolute nightmares because I'd just kinda drift off in interviews and not really listen to a word that they were saying, I could see the mouth moving but my mind would be thinking of something else. They would pick up on that each time and... my applications were always, I was always granted interviews but it was when it came to the interviews I just kind of drifted off each time.</p> <p>Z. Do you think any of those things you have talked about have been affected since you have received your diagnosis?</p> <p>I have tried to... since we have talked about a few things with Marjorie, I have tried to do some of the things we talked about at work where I organise myself in different ways to do different things at different times so that has got a bit better I think people at work have noticed I am a little bit better organised. Relationship wise with people I don't think that has particularly improved with anyone. I still struggle to stick with anything I still find myself like when I'm at work just every time I try and start a piece of work I do just find myself looking at something on the internet and not knowing how I've even got there my mind is just off zig zagging off into looking at different things. It probably would have helped since the diagnosis if I had been on a stable medication but the first – three different one's have been given me with differing side-affects which haven't helped so I have been on them for a couple of weeks and then taken off them and having to wait another 6 to 8 weeks to get another appointment so it is has been a bit up and down really but I think it is starting to .. the one I'm on at the moment seems to be a bit better so things do seem to be improving a little bit.</p> <p>Z. and has the diagnosis changed the way you think and feel about yourself?</p>	<p>Dad dismissed diagnosis. Dad didn't believe diagnosis. Never gone far at work.</p> <p>Got current job because only viable candidate.</p> <p>Interviews always nightmares. Drift off in interviews. Not listen in interviews. Could see mouth moving, mind wandered. Interviewers noticed not concentrating. Job applications good. Always granted interviews.</p> <p>Talked with CP Tried solutions at work. Tried to organise myself differently at work. Organisation at work got better. People at work noticed better organised. Relationships not improved. Still struggle to stick with anything. Still get distracted at work. Looking at internet instead of work. Mind zigzagging. Stable medication would have helped. Tried 3 medications. Side-effects from medications. On and off medications. Wait 6-8 weeks between medication appointments. Current medication better. Things are improving.</p>
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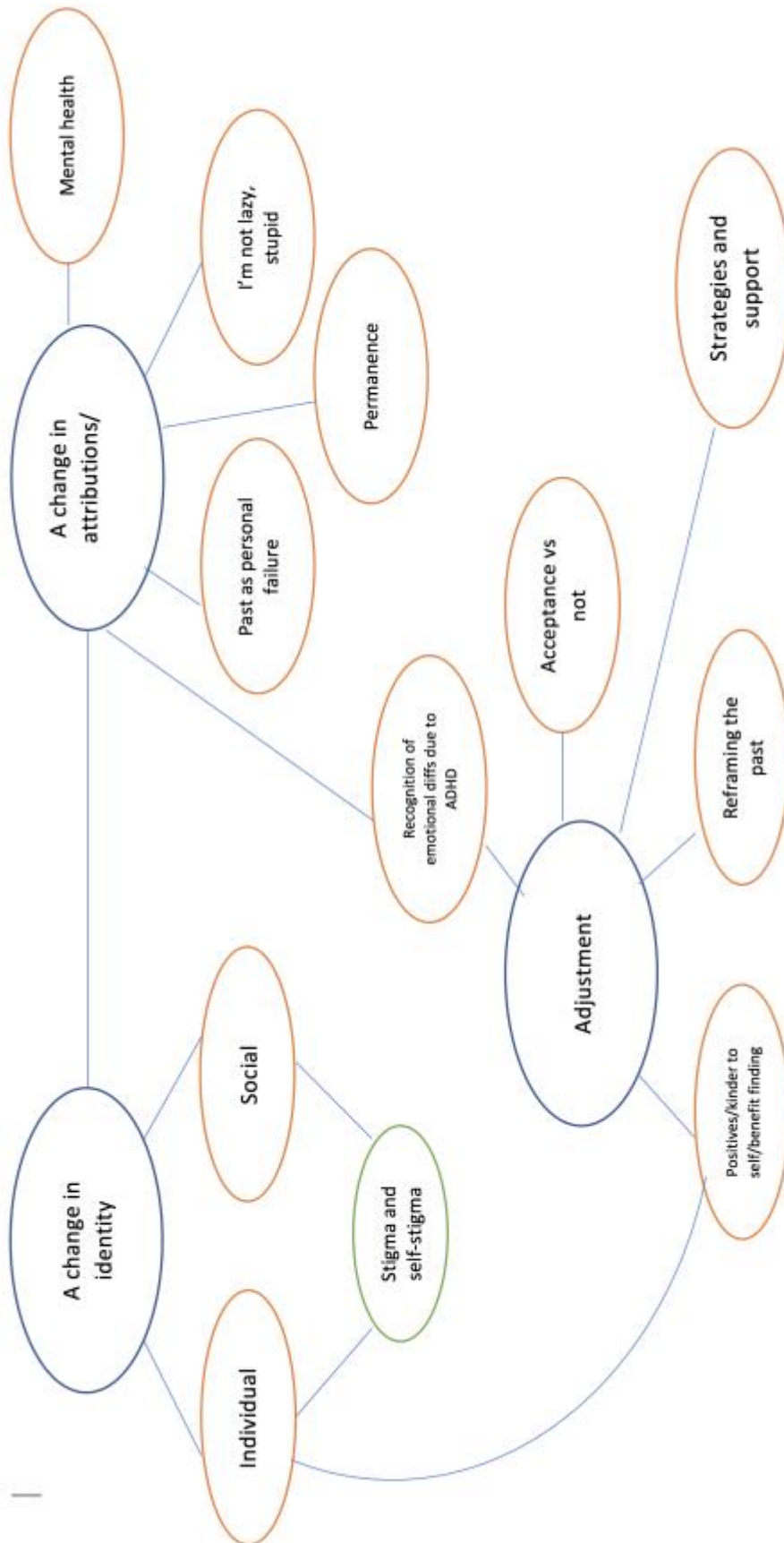
<p>410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469</p>	<p>I'm a little bit less down on myself than I was I think because I know it is probably out of my control but it has given me a kind of anxiety in that this latest medication, which is the last chance really, if this one don't work or if I can't tolerate this then it's Its not, I would have thought before I might just change one day but now I know am not going to just change if the medication don't work it is a 100% down to me to have to really try and find ways around the problems I have got with it. That is a bit intimidating I guess knowing that. Beforehand I always thought I would grow out of it but it hasn't changed. (Z. It has added a few worries) yes a bit of pressure really yeh. (Z. What do you mean by pressure?) Well pressure no I have to say not pressure a bit of anxiety that if the medication don't work then it is down to me having to find ways of dealing with it in everyday life and just accept that this is going to be the way I am going to be.</p> <p>Z. and how about the support available to you, has the support changed the impact of receiving the diagnosis?</p> <p>I think people like Marjorie have made it feel a lot more positive than what I would have initially thought, because like she said it's always been there and you're just now trying to deal with it and you wouldn't want to get rid anyway as 100% it is part of who you are anyway. But to be fair the guy in the mental health place has been pretty good as well. It's hard to really say ... how I really feel about it I don't know how I would have been if I had got a diagnosis before.</p> <p>Z. Is there anything that we touched on that you want to go back to or anything you feel that is important to you would like to say that we haven't brought up yet?</p> <p>There was something I thought of earlier but I can't remember forgot what it was now. I would say as well that previous relationships with people have broken down because you get the intense boredom – you always want something to change so like when you start going out with someone and after</p>	<p>Less down on myself. Know it's out of my control. Anxiety about medication being last chance. Anxiety about tolerating medication. Thought I might just change. Now I know I'm not going to just change. If medication doesn't work, 100% down to me. Try to find ways around problems. Intimidating knowing it's down to me. Thought I would grow out of ADHD. ADHD hasn't changed.</p> <p>Find ways to deal with everyday life. Accept this is the way I am going to be.</p> <p>CP made diagnosis feel positive. CP said ADHD has always been there. Trying to deal with it now. CP - wouldn't want to get rid of ADHD ADHD is part of me. MH worker good. Hard to say how I feel as don't know how I would feel with earlier diagnosis.</p> <p>Relationship breakdown due to intense boredom. Want something to change in relationships. Go off with someone new after 3 weeks.</p>
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<p>470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529</p>	<p>about 3 weeks I would go off with someone new. That just kept happening for ages and then this time I have just had to try and shut that down that's quite hard and then you start to think relationship wise that are you with the right person or are you just getting bored all the time with everything and everyone.</p> <p>Z. So having received the diagnosis and maybe understanding a bit more about you does that have any effect on those relationships</p> <p>I don't know em.. I just thought I was getting bored of people to be honest all the time and always wanting something to change. I don't know if the diagnosis has made any difference. I think it has probably made me realise that I do have to realise that eh I can't just keep changing, not just that but everything in my life, it's like everything, I've just been recycling just to try and keep myself, even just to feel something like a level of interest in anything rather than just essentially flatlining like my enjoyment (<i>gestures a flat line with hand</i>) because it's just like been really intense boredom so I just like do things like with relationships it was constantly changing them. I was like ridiculous for getting into debt by constantly changing cars changing phones, buying stuff I didn't need. So stuff like that and the diagnosis made me realise that the answer isn't in doing that and I have now got to stop doing that no matter how hard, I still find myself now wanting to do stuff I have to keep trying to stop.</p> <p>Z. Anything else you want to go back to or we didn't cover.</p> <p>The only thing that made me anxious about getting the diagnosis as well was about how long it took, everything like I say was quite a long drawn out process and it did make me wonder at times whether it was actually ever going to happen or if I was going to be left hanging or if it is when you hear about the news with all these different cuts and whether it was going to be one of the things that because so many people say it doesn't even exist it would be one of those things that gets shoved to one side and got rid of and you'd just be left to deal with it on your own. Because I mean I looked at a lot of things because</p>	<p>Kept happening. Now try to stop this and stay with one person. Question if with right person. Question if would get bored with everything and everyone.</p> <p>I was getting bored of people. Always wanted change in relationships. Don't know if diagnosis made a difference. Diagnosis = realise I can't keep changing partners and everything in life. Recycling to feel something, to keep interest. Flatlining of enjoyment. Intense boredom in relationships. Keep changing partners. Getting into debt. Changing cars, phones. Buying stuff I didn't need. Diagnosis = realise got to stop buying/changing. Still want to buy/change but try to stop myself.</p> <p>Anxious about length of time for diagnosis. Diagnosis = long process. Wondered if diagnosis would ever happen. Wondered if left undiagnosed due to budget cuts.</p> <p>People say ADHD doesn't exist. Worry ADHD would get neglected. Worry left to deal with ADHD on own.</p>
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530	there is an adult attention deficit forum which I joined and looked at there is a	Joined adult ADHD
531		forum.
532	lot of people on there who seemed to have the same sort of concerns about	Others on forum same
533		concerns as me.
534	things I mean like the timescale of mine which was about probably 11 months	
535		11 months to get
536	is nothing compared to a lot of peoples. I think people are looking at 2 or 3	diagnosis.
537		Others on forum 2-3
538	years. No I don't think there is anything else.	years to diagnosis.
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Appendix P: Spreadsheet of grouped codes

Appendix Q: Thematic map in progress



Appendix R: Final thematic table

Overarching theme	Sub theme	What is included in the theme
Looking back	Different, faulty	How I saw myself
	Relief and regret	What if I was diagnosed earlier
	Reframing	Attributions ADHD is real, neuro basis = permanent I'm not stupid, lazy, crazy
Looking inwards (with acceptance)		Change in self-concept
		Identify as ADHD
		Who am I?, vs I am unchanged Knowing limits/abilities
Looking outwards	Labelling: disability, stigma	Sharing as positive: belonging Sharing as negative: work, friends, society
	Social comparison	Comparing self to others The way others see me
		ADHD within families: a shared experience