Barriers to Being Seen: The Interpersonal Experiences of AFAB University Students with ADHD in South Africa

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Signed by candidate Date: 10 February 2024

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Abstract

Adults who were assigned female at birth (AFAB) are an under-represented group in ADHD literature and little is known about their lived experiences. This study aimed to explore how AFAB university students with ADHD experience interpersonal relationships. Using an interpretive phenomenological framework, 12 AFAB students from a South African university were recruited to participate in individual semi-structured interviews. Reflexive thematic analysis was employed to synthesise the data and generate a narrative account of the following two overarching themes, '*compromised connection and vulnerability'* and '*strategising to find connection'*. The findings depicted that the participants' interpersonal experiences were marked by frequent invalidation, judgement, and misunderstanding from those in their life. These factors were described as barriers to experiencing close and fulfilling interpersonal relationships. However, the participants also described several strategies that they believed buffered their negative social experiences. Whilst these strategies were shown to limit conflict and alienation, several of them were also demonstrated to be exhausting and detrimental to the participants' overall wellbeing. As such, this study highlighted the importance of mutually accommodating and supportive interpersonal relationships for AFAB adults with ADHD.

Keywords: interpersonal relationships, ADHD, AFAB, interpretive phenomenology

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Glossary of Terms

Apartheid	An Afrikaans word meaning ‘separation’. This term describes segregation based on specific criteria, usually race or ethnicity. In the South African context, this denotes a political period of formalised (via legislation) racial segregation from 1948 to 1994 (Kleintjes & Schneider, 2023).
Assigned Female/ Male at Birth	Terms denoting sex assigned at birth. This is thus inclusive of people of all genders, and intersex people, who fit the respective descriptions (American Psychological Association of Graduate Students [APAGS], 2015).
Boy/Girl	A child, 12 or younger, with a masculine/feminine gender identity respectively (APAGS, 2015). These terms do not indicate sex, although previous literature has sometimes used them in this manner.
Emotional Dysregulation	A term denoting difficulty in regulating or managing one’s emotions, often observed as irritability, emotional outbursts, or emotional lability.
Female/Male	Terms indicating one’s sex as prescribed by certain differentiating biological and/or physiological criteria (APAGS, 2015).
Gender	A socially constructed set of behaviours and traits that are prescribed and believed to be associated with one’s sex, as dependent on context and culture. Nonetheless, an individual’s gender identity relates to their psychological sense of self and is not indicated by their sex (APAGS, 2015).
Genderism	An ideology denoting that both sex and gender are binary and that one’s gender is a reflection of their sex assigned at birth (i.e., that all people are or ought to identify as cisgender; APAGS, 2015).
Man/Woman	An adult with a masculine/feminine gender identity respectively. These terms do not indicate sex, although previous literature has sometimes used them in this manner (APAGS, 2015).
Neurodivergent	Describing neurological differences, such as those observed in people with ADHD and ASD, amongst others.
Neurotypical	Describing typically expected brain functioning.
Object Permanence	A concept that names one’s understanding that something still exists despite not seeing it. This term is often used in relation to ADHD-diagnosed individuals’ common difficulties with remembering things not in their present sight.
Race	A set of criteria (e.g., ethnicity, ancestry, physical characteristics) that humans are often grouped by.
Rejection Sensitivity Dysphoria	A non-diagnostic term referring to overwhelming feelings of hurt in response to real or perceived rejection (Normansell & Wisco, 2017); often used in relation to its common occurrence in individuals with ADHD (Littman, 2023).
Stims	A short version of the term ‘self-stimulating behaviours’, denoting several self-soothing behaviours used quite frequently by neurodiverse populations.
Theory of Mind	Denoting the understanding one has that other people may have different perceptions, emotions, intentions and thoughts to one’s own.

CHAPTER 1: AN INTRODUCTION

Attention-deficit/hyperactivity disorder (ADHD) is a neurological condition that affects an estimated 2.5% of the global adult population (American Psychiatric Association [APA], 2022). Having the condition is associated with poor social outcomes, such as increased interpersonal challenges like conflict, rejection and neglect (APA, 2022). Moreover, up to 80% of adults with ADHD have at least one other psychiatric condition (Choi et al., 2022), and studies have shown that those assigned female at birth (AFAB)[1] are even more psychologically impaired (Hinshaw et al., 2022). Literature shows that good social support and positive peer relations mediate the link between people with ADHD and comorbid mental health difficulties (Meinzer et al., 2015; Powell et al., 2020). However, we know very little about how adults with ADHD experience interpersonal relationships. This study sought to address this so as to contribute to a better understanding of how adults with ADHD experience interpersonal relationships.

This chapter will introduce the current study by providing a background to ADHD and rationale for focusing on AFAB adults as a group requiring attention in ADHD research. I will then examine the broader societal context within which the study is situated. This will lead to the presentation of the study rationale and research objectives, followed by the structure of this paper.

The History of ADHD

While paediatrician, George Still, is frequently credited as the first to describe ADHD, Scottish physician, Alexander Crichton, more than a century earlier, described a similar condition said to be present primarily in young boys[2] (Palmer & Finger, 2001). Crichton published a medical *Inquiry* in 1798, divided into three separate books (Palmer & Finger, 2001). In the second chapter, ‘On Attention and its Diseases’, of the *Inquiry*’s second book, entitled ‘The Natural and Morbid History of the Mental Faculties’, the physician described a disorder

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[1] Whilst literature often uses the term ‘female’ to reference sex, the term is exclusionary to gender diverse and intersex populations. Thus, referring to sex assigned at birth acknowledges that these populations are often implicated in the findings of studies that may have used non-inclusive terminology.

[2] This was the term used by Crichton, notably in an era where genderism was more prominent. Where markers like ‘boys’, ‘males’, ‘females’ etc. are used in this report, it is to reflect the terms used by the authors of the literature cited.

characterised by persistent attention difficulties (Palmer & Finger, 2001). He defined attention as "the ability to focus on one thing while excluding others" (Palmer & Finger, 2001, p. 68), and noted that there are instances where anyone might display inattention due to contextual factors such as their motivational or emotional states. He hence noted that inattention in a single context or similarly isolated circumstance was insufficient to decipher the presence of a disorder.

However, Crichton described two differing types of pathological inattention, where difficulties occurred "with constancy" (Palmer & Finger, 2001, p. 70) beyond what was circumstantially expected. One form involved patients' diminished ability to pay attention; and another where they were 'excitable', as depicted by often switching their attention and easily being distracted by external stimuli (Palmer & Finger, 2001). While the inability to pay attention was ascribed to physical circumstances such as age, diet, injuries, or illnesses, the attention difficulty related to excitability he observed in otherwise "healthy and intelligent boys" (Palmer & Finger, 2001, p. 70). Crichton noted that these 'excitable' patients experienced internal agitation, or "an unnatural degree of mental restlessness" that they themselves called "the fidgets" (Crichton, 1798, as cited in Palmer & Finger, 2001, p. 69). He noted that children were born with this condition, and that symptoms were evident in early years, but often improved with age (Palmer & Finger, 2001).

Traits that resemble ADHD were later revisited – and gained heightened public attention – due to George Still (Palmer & Finger, 2001). In his series of lectures held in London in 1902, Still also described children with attention deficits. However, the paediatrician placed a large emphasis on *morality*, describing children who displayed age-inappropriate hostility, dishonesty, selfishness, lack of inhibition, deviousness and decadence. He described the aetiology of these difficulties as either due to factors such as tumours, heritability (e.g., a family history of epilepsy), intellectual impairment, or moral absence/dissipation. Lastly, Still described these deficits to be present in boys at 3 times the prevalence noted in girls, in addition to mostly being present by age 8 in those he studied (Palmer & Finger, 2001). Thus, regardless of the aetiology, Still saw the condition as a behavioural issue that was of concern to society at large.

In the years to follow, several other conceptualisations of ADHD were developed, with frontal lobe and other brain anomalies linked to what was then considered a 'restlessness syndrome' (e.g., Levin, 1938, as cited in Palmer & Finger, 2001). With the publication of the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-2), ‘Hyperkinetic Reaction of Childhood’ was introduced as the first formal documentation of an ADHD-adjacent syndrome (APA, 1968, as cited in Epstein & Loren, 2013). Subsequently, researchers continued their efforts to define symptoms associated with attention deficits, and to make clear distinctions between what might instead be indicative of other conditions (Palmer & Finger, 2001). Debates about whether these symptoms constituted brain differences or behavioural/moral issues persisted.

It is now recognised that much of what Still described may better be attributed to comorbid oppositional, conduct and learning disorders than ADHD alone (Palmer & Finger, 2001). On the other hand, Crichton’s work did a better job of describing contemporary ADHD inattentive type (ADHD-I). Nonetheless, the work of these two physicians largely explains why ADHD was initially considered a childhood disorder that affected those assigned male at birth (AMAB) at a greater prevalence than AFABs. While this is improving, many health practitioners still under-recognise ADHD in AFAB and adult populations, and not enough is understood about the condition in these sub-groups (Hinshaw et al., 2022).

The Aetiology of ADHD

A range of hypotheses exist to decipher ADHD’s complex aetiology, with both physiological and environmental circumstances considered potential risk factors. These include gestational complications such as maternal stress and substance use, and neonatal factors such as low birth weight, premature birth, neurotoxin exposure, and early malnutrition (APA, 2022; Sciberras et al., 2017; Thapar et al., 2013). There is also a significant genetic association with the condition, where parental ADHD and other parental psychiatric conditions have been linked to its occurrence (Sciberras et al., 2017; van Dyk et al., 2015). Most notably, however, ADHD is hereditary in over 70% of cases, depicting a strong link between familial/parental ADHD and subsequent ADHD in children (APA, 2022).

ADHD prevalence has also been linked to low socio-economic status (SES) (van Dyk et al., 2015; Vrba et al., 2016). Lower middle-income countries (LMIC), like South Africa, exhibit several risk factors associated with higher ADHD prevalence (Vrba et al., 2016). These are, in addition to those already identified, low parental education level and/or income, childhood trauma, predominant non-maternal caregiving, and compromised family cohesion, such as via single or absent parenting (van Dyk et al., 2015; Vrba et al., 2016). Similarly, the early bonding between infant and mother, demonstrated by factors such as breastfeeding for more than three months (van Dyk et al., 2015), has been noted as a protective factor for ADHD in children. These factors point to attachment and bonding deficits between mother and child potentially influencing the trajectory of ADHD in children (van Dyk et al., 2015). However, whilst these and other familial "interaction patterns" (APA, 2022, p. 172) have been linked to the prognosis of ADHD, no causal link has been determined. Nevertheless, ADHD is understood to be a neurological difference, explaining studies' continuous examinations of genetic and epigenetic risk factors, and the overall physiological determinations of the condition (APA, 2022; Sciberras et al., 2017).

The Diagnostic Criteria of ADHD

ADHD is characterised by difficulties in two overarching symptom domains: inattention and hyperactivity/impulsivity (APA, 2013). The fifth edition of the DSM (DSM-5) categorises the condition into three subtypes, namely ADHD-I, the predominantly hyperactive/impulsive presentation (ADHD-H), and the combined presentation (ADHD-C). ADHD-I and ADHD-H respectively consist of nine distinct symptoms, where individuals aged 16 and younger meet the criteria for diagnosis if they present with at least six of these. For those who are 17 and older, only five symptoms need to be present to meet diagnostic threshold. Where one meets the criteria for both subtypes, they are diagnosed with ADHD-C (APA, 2013; see Appendix F).

ADHD symptoms should clearly impede the functioning of an individual, be present for a minimum of six months, be present in at least two different settings (e.g., work, home, or school), and not be better explained by another mental health condition (APA, 2013). Lastly, the DSM-5 prescribes symptom onset to be by age 12 in all individuals (APA, 2013).

The above diagnostic criteria reflect several changes from the previous edition of the diagnostic manual. The DSM-5's symptom onset of age 12 (previously age 7), symptom threshold being reduced to five in older adolescents/adults (previously six), and noting relevant impairment, rather than the more stereotypical or external presentations that were supposedly more indicative of 'clinical' significance, are some of the revisions made from the DSM-4's criterion (APA, 2013; Epstein & Loren, 2013). These revisions have several implications.

Diagnostic Implications

Following the ideas of early authors like Crichton and Still, ADHD symptoms were until recent years presumed to negligible or less impairing in adulthood. This was potentially linked to overwhelming notions that the condition was of a 'behavioural' nature prior to the DSM-5, where several indicators in the previous edition of the manual implied more 'disruptive' and externalised traits (Substance Abuse and Mental Health Services Administration, 2016). Transiently, symptoms were thought to persist into adulthood in only a percentage of people, eventually leading to present-day understandings that the condition is chronic and persistent (Attoe & Climie, 2023; Jensen & Vamosi, 2023). The revised diagnostic criterion in the DSM-5 reflects this by better accommodating the recognition of adult ADHD (Epstein & Loren, 2013).

For one, it is suggested that with age, as functional demands increase, ADHD symptoms that may have previously been unnoticed or compensated for might become more evident (Epstein & Loren, 2013). Hence, impairment may only be noted as these new challenges emerge, thus resulting in clinical referrals in older populations. More so, adults are less likely to remember their early childhood experiences or have access to informants (APA, 2013). Increasing the age of symptom onset accommodates this reality (Epstein & Loren, 2013). Additionally, as memory difficulties are commonly related to ADHD, this further complicates the recall of early childhood experiences. As such, individuals referred for diagnosis later in life are now more likely to rightfully meet the diagnostic criteria (Epstein & Loren, 2013).

Missed and Late-Diagnosed ADHD

Despite the DSM-5's revisions, prevailing misconceptions about ADHD compromise adults who went undiagnosed in childhood. Contradicting perceptions that symptoms dissipate with age, a systematic review on ADHD in older adults (aged >50) found that inattentive symptoms are largely unchanging over the lifespan, whilst hyperactive ones persist as more subtle traits, such as restlessness, excessive talking, anger outbursts, impatience, and careless driving (Torgersen et al., 2016). As researchers begin to more accurately recognise that ADHD is chronic, studies on adult samples are gradually increasing.

Nonetheless, females are greatly under-represented in ADHD literature (Attoe & Climie, 2023). For one, out of a total 243 studies published in the *Journal of Abnormal Child Psychology* between the release of the DSM-3-revised and the DSM-4 (i.e., a 6-year period) only 19% of all participants in the studies on ADHD were female (Hartung & Widiger, 1998, as cited in Attoe & Climie, 2023). Moreover, where participation was limited to one sex in these 243 studies, 99.6% used males. This gender bias in youth samples largely explains why neurodevelopmental conditions, like ADHD, are inadequately understood in AFABs (Attoe & Climie, 2023).

What has been well established, however, is the unfortunate outcomes for individuals who receive insufficient intervention to manage and accommodate their ADHD. When unaware of, and thus untreated for their ADHD, individuals are more likely to experience functional impairments and comorbid health difficulties (Katzman et al., 2017; National Institute for Health and Care Excellence [NICE], 2019). For one, increased years without stimulant medication is shown to correlate with subsequent substance abuse in ADHD populations (NICE, 2019), while "early treatment" is demonstrated to have a "protective effect on future development of depression [and] bipolar disorder" (Katzman et al., 2017, p. 10). These statistics are concerning when noting that differing symptom presentations, in addition to commonly occurring comorbidities, makes certain demographics less likely to access ADHD treatment (Katzman et al., 2017; Torgersen et al., 2016). Hyperactive traits, for example, often present differently in AFAB and adult populations, thus obscuring relevant stakeholders' recognition of ADHD in these populations (Katzman et al., 2017; Young et al., 2020).

University students. University students have been found to face marked challenges in receiving an accurate and timely diagnosis of ADHD (Katzman et al., 2017; Sedgwick-Müller et al., 2022). This has been attributed to several factors, including the high prevalence of comorbidities, like depression and anxiety, complicating the recognition of underlying ADHD symptoms (Sedgwick-Müller et al., 2022). Considering concerning rates of informal stimulant usage in this population, researchers further suggest that university students may be self-medicating for undiagnosed ADHD (Katzman et al., 2017). Moreover, university students are often academically inclined, and intellectual giftedness (IG) has been shown to interfere with the detection of ADHD in this population (Sedgwick-Müller et al., 2022).

AFABs. Studies corroborate that AFABs are also disadvantaged in terms of receiving timely referral and treatment for ADHD (Attoe & Climie, 2023; Hinshaw et al., 2022; Young et al., 2020). Several factors contribute to this, such as disparities in clinical referrals in childhood, with ratios ranging between 3:1 and 16:1 for males to females respectively (Young et al., 2020). Teachers are one of several stakeholders that often underreport and underestimate ADHD symptoms in female children and adolescents (Katzman et al., 2017; Young et al., 2020). Similarly, healthcare professionals often attribute ADHD symptoms in AFABs to other conditions, while accurately identifying these as ADHD-related in AMABs (Nussbaum et al., 2012; Hinshaw et al., 2022).

In adulthood, contrastingly, ADHD prevalence ratios in males to females become roughly equal (Young et al., 2020). This is proposed to be a result of a greater reliance on self-report measures, for one. Literature has also noted that ADHD symptoms are often considered socially inappropriate for AFABs to exhibit (Kok et al., 2016), resulting in them masking to avoid stigma and rejection (Young et al., 2020). Unfortunately, masking further hampers ADHD recognition and diagnosis (Katzman et al., 2017). Masking, moreover, precipitates comorbid mental health difficulties (Young et al., 2020). As with university students, these comorbidities complicate the recognition of ADHD in this population.

Vulnerabilities Associated with Adult ADHD in South Africa

Research on adult ADHD is especially scarce in South Africa. However, with the launch of the South African Society of Psychiatrists' Special Interest Group for adult ADHD in 2015, this is improving (Schoeman & Liebenberg, 2017). From these growing publications, social outcomes associated with adult ADHD yield similar findings to international statistics. For one, Schoeman and colleagues (2017) identified several barriers that adults with ADHD in the country face to receiving care. These include invalidation from the public, misconceptions about the pertinence of symptoms in adulthood – including from health care providers, a limited understanding of how symptoms may present differently with age, stigma, and the belief that ADHD is over-diagnosed (Schoeman et al., 2017). It is thus dismaying that due to resource and other constraints, ADHD is instead likely under-diagnosed locally (Vrba et al., 2016).

ADHD-diagnosed adults in South Africa experience worse education outcomes and greater unemployment than controls (Van Wijk, 2020). Moreover, a local study on ADHD-diagnosed adults with private health insurance found that they experience numerous health complications, resulting in doubled expenses in comparison to other adults (Schoeman & de Klerk, 2017). This finding is especially concerning considering that adults with private health insurance often depict an elite demographic in the country.

Preliminary findings on tertiary students in South Africa are similarly concerning. In their study on first years enrolled at the University of Cape Town (UCT) and Stellenbosch University, Bantjes and colleagues (2021) determined that those who reported an ADHD diagnosis within 12 months of the study (25.9% of respondents) were more than twice as likely to fail or drop out. This figure was determined after controlling for variables like comorbid conditions and sociodemographic factors (Bantjes et al., 2021).

It is also probable that the difficulties experienced by AFAB adults with ADHD internationally similarly affect this demographic locally. This is perhaps corroborated by a study that provided preliminary estimates of ADHD prevalence in undergraduate university students. Although varying across instruments, with prevalence ranging from 13% to 19%, this study determined that the figures observed were higher than the number of students in the total sample (*N*=402, 82% AFAB) who reported an ADHD diagnosis in their lifetime (*n*=25, approximately 6%; Burke et al., 2011). This thus raises the possibility that some participants had undiagnosed ADHD. Nonetheless, no large-scale and generalisable epidemiological studies on ADHD currently exist in the country.

Examining the Broader Context

Mental Healthcare in South Africa

South Africa's historical background has led to devastating outcomes for the accessibility of mental healthcare to the previously marginalised racial groups of the Apartheid regime (Kleintjes & Schneider, 2023). According to Kleintjes and Schneider, from early colonisation, mental illness was first heavily stigmatised, such that individuals affected were treated with hostility or detainment. Later, however, it was acknowledged that the unique and highly stressful circumstances of Apartheid likely caused or exacerbated mental health difficulties. This propelled developments such as the building of psychiatric hospitals and the formalisation of new specialisations, such as 'clinical psychologist'. People with mental health difficulties were thus recognised as requiring care rather than ostracization. However, black[3] populations were subjugated by the psychological practices in the country. These inequalities were a result of the state's rebuttal of the "brutality" (p. 3) underlying the Apartheid regime; the dominant implementation of Western medical models that undermined traditional healing practices; the academic boycotts placed on South Africa at the time; and the 'universal' outlook on psychological well-being that negated the relevance of cultural and socio-economic factors on individuals' functioning. Consequently, discrimination against black populations in the country

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[3] South African literature often uses this term to encompass the multiple racial groups (namely Black, Indian and Coloured) to represent all the people who were marginalised under the Apartheid system of classification and segregation.

was enforced, justified, and perpetuated by the biased ideologies underpinning the field of psychology during Apartheid (Kleintjes & Schneider, 2023).

Whilst legislated segregation ended with Apartheid, the legacy of this period continues to see hampered mental healthcare accessibility for certain social groups in South Africa (Meyer et al., 2019). Historic legislations such as the Group Areas Act account for the country's prevailing inequalities according to race and class, where, for one, healthcare facilities/services are still concentrated in the former 'white' areas and are thus less accessible to the primarily black populations still residing in other regions. Additionally, psychological distress is often highly prevalent in these communities due to greater exposure to violence, poverty, hunger, and trauma. Compounding this, however, prevalent stigmatising views about mental illness often discourage individuals from seeking psychological care via the often public means that are most accessible to members of these communities (Meyer et al., 2019).

Minority Social Groups

Disproportionately detrimental outcomes have also been exhibited in South African tertiary students as per their social group. In a recent local study, the prevalence of 11 common mental health diagnoses in university students showed that gender non-confirming, female, and sexual minority students were at a greater risk of psychological impairment than other demographic groups (Bantjes et al., 2023). This study also found that black (i.e., Indian, Black-African, and Coloured) students attending a historically white institution (HWI) were more at risk of having any disorder than white students. Notably, although ADHD literature often refers to sex and/or gender as binary categories, research has found that transgender and gender diverse populations have a higher prevalence of ADHD than cisgender ones (see Goetz & Adams, 2022, for a review). Thus, gender non-conforming ADHD-diagnosed university students might be similarly prevalent in South Africa.

Research has deduced that historically marginalised racial groups may have greater difficulties adapting to tertiary due to finding this new environment "distressing, isolating, and discriminatory" (p. 101), and due to phenomena such as imposter syndrome (McClain et al., 2016). Furthermore, locally, students from socially disadvantaged backgrounds are seen as experiencing added distress in university due to factors such as being less prepared to cope with academic demands; often being depended on to attenuate their families' economic hardship; living far from family; and racism and cultural discrimination (Young & Campbell, 2014). HWIs in South Africa often have a “white male, Eurocentric culture that many black and female academics and students experience as alienating” (Young & Campbell, 2014, p. 361). As such, locally, potentially inflated vulnerabilities exist for university students with ADHD who are also members of these at-risk demographics.

Rationale and Research Question

As noted, AFAB adults with ADHD are vulnerable to several worrying psycho-social experiences. Meagre existing literature on this population contributes to these poor outcomes. It is thus important to investigate how AFAB adults with ADHD, in South Africa, experience interpersonal relationships. In particular, how this might inform their access to social support. An interpretive phenomenological approach was used to address the following overarching question: ‘How do AFAB adults who are diagnosed with ADHD experience interpersonal relationships?’.

Structure of Thesis

This chapter outlined the history and contemporary conceptualisations of ADHD, along with matters concerning epidemiology, aetiology, and the concomitant challenges associated with the condition. Chapter 2 will review literature on the social experiences of ADHD populations. Chapter 3 will detail my methods and relevant ethical considerations. Chapter 4 will present my findings as organised into themes and subthemes. In Chapter 5 I will discuss these findings and their implications. I will then discuss this study’s strengths and limitations, offer directions for future research, and present my conclusion.

CHAPTER 2: LITERATURE REVIEW

This chapter will review the literature on the social outcomes of ADHD populations. I will first provide an overview of the risks associated with ADHD in adults, further detailing how university students and AFABs are vulnerable. This will be followed by an examination of the limited South African literature pertaining to the social experiences of ADHD populations. I will then examine what international research details about social impairment in ADHD populations, followed by specifically examining what literature has determined about their interpersonal relationships.

Risks and Outcomes Associated with Adult ADHD

Adult ADHD commonly co-occurs with other mental health diagnoses, with up to 80% of this population being estimated to have at least one comorbidity (Choi et al., 2022). Anxiety, depression, bipolar, eating disorders, substance use disorders, personality disorders, impulse-control disorders, autism spectrum disorder (ASD), and obsessive compulsive disorder (OCD) are shown to commonly co-occur in this population (Katzman et al., 2017; Young et al., 2020). Adults with ADHD are also generally at risk of greater physical health concerns, as seen via visiting physicians more often and having a lower life expectancy than other adults (Katzman et al., 2017). On average, they also display riskier sexual behaviours, often being sexually active earlier, having more partners, using contraception less, being treated for sexually transmitted diseases (STDs) more often, and engaging in more casual sexual activities (Young et al., 2020). Adults with ADHD also often have higher rates of sensation-seeking, substance misuse, altered sleep, impeded emotional self-regulation, and more suicidal ideation in their lifetime than controls (Guipponi et al., 2020). Furthermore, whilst third parties depict substance use as harmful, studies indicate that adults with ADHD report finding psychotropic, and sometimes illicit, substances like marijuana and cocaine calming or therapeutic (Canela et al., 2017; Mitchell et al., 2016).

The Vulnerabilities of University Students and Emerging Adults

University students with ADHD have been found to be particularly vulnerable. For one, emerging adulthood is a stressful transition period that often induces mental health difficulties, and university students with ADHD are shown to face elevated challenges in adapting to these transitions (Meinzer et al., 2015; Sedgwick-Müller et al., 2022). In their study on undergraduate university students (72.3% AFAB), Meinzer et al. (2015) noted that participants with increased

ADHD symptoms had worse relationships with their parents, and increased depressive symptoms. More so, positive parental relationships were found to mediate depressive symptoms in students with elevated ADHD symptoms (Meinzer et al., 2015). Interestingly, this study used self-rating measures to indicate symptoms, and thus heightened symptoms were not necessarily indicative of formal diagnoses. Moreover, this study omitted information on social support from peers and other loved ones (Meinzer et al., 2015). Nonetheless, this study highlights the importance of parental support in emerging adulthood.

Sedgwick-Müller et al. (2022) further highlight the vulnerability of university students with ADHD. For one, co-occurring IG and ADHD can interfere with the detection of one or the other in people with both. Thus, in their article on university students, Sedgwick-Müller and colleagues (2022) suggest moving away from notions of ADHD being a learning difficulty in order to provide timely support and intervention to students at risk of going undiagnosed. This study also highlighted the importance of screening university students with anxious and depressive symptoms for ADHD, noting that these are largely comorbid in this population. Interestingly, Young et al. (2020) highlighted intellectual functioning impairments as more prevalent in females with ADHD than males. I however wonder if this might reflect discrepancies in ADHD recognition in AFABs, where those with such impairments may be more often diagnosed, as proposed to occur in autistic females (Livingston & Happé, 2017).

The Vulnerabilities of AFABs

As discussed (see Chapter 1), insufficient literature details how ADHD presents in AFABs. The implication of this is that ADHD is predominantly understood as per its presentation in young boys. However, contrary to young boys, who often exhibit externalised and hyperactive ADHD traits, AFAB populations are demonstrated to often display internalised symptoms, in addition to presenting with ADHD-I more than other ADHD subtypes (Hinshaw et al., 2022; Young et al., 2020). One hypothesis for greater symptom internalisation is due to overt displays of ADHD traits contradicting ideal femininity in many societal contexts (Hayashi et al., 2019; Young et al., 2020). Research has proposed that due to this, girls who display these traits may often be seen as “deviant” and may “stand out from their peers to a higher extent than do boys” (Kok et al., 2016, p. 3). Moreover, literature found that peer dislike and victimisation uniquely amplified the link between ADHD symptoms and depression in girls, but not boys (Roy et al., 2015, as cited in Kok et al., 2016). As such, AFABs of all ages often mask their ADHD symptoms.

However, even where externalised signs are apparent, stakeholders are shown to misattribute these in AFAB populations. For one, a review that examined the clinical implications of ADHD in females found that practitioners commonly misdiagnose bipolar disorder in those with hyperactive/impulsive symptoms, and misdiagnose dysthymia for those with predominantly inattentive traits (Nussbaum, 2012). At times, nonetheless, other mental health conditions are indeed comorbid, but ADHD symptoms are obscured by these (Young et al., 2020). As such, AFAB populations are prone to under-diagnosis of ADHD.

Years of untreated ADHD, and experiences of resultant failures, have been indicated to result in negative automatic thought-patterns in females (Attoe & Climie, 2023; Hinshaw et al., 2022). For one, women with ADHD may consider themselves “lazy”, “incapable”, and “crazy”, and often these labels may have also been said to them at some point in their lives (Smyth et al., 2015, p. 44). More so, personal successes have been examined by research as often attributed to external factors in this population, whilst failures are seen as personal faults (Attoe & Climie, 2023). This magnifies negative thought processes via increased self-blame.

Research has linked these internalized cognitions to women opting for ‘self-medication’ via detrimental means such as illicit drug usage and risky sexual behaviours (Attoe & Climie, 2023; Canela et al., 2017; Young et al., 2020). Worsening this, these thought processes depict direct pathways to the development of internalized conditions like depression and anxiety, which co-occur in females with ADHD at a greater prevalence than males (Young et al., 2020). By adulthood, AFABs with ADHD are found to be at greater risk of non-suicidal self-injury (NSSI), suicidal ideation, in-patient admission, substance misuse, teenage and unplanned pregnancies, physical and sexual abuse, dysfunctional driving, criminality, financial issues, and severe illness (e.g., schizophrenia; Fuller-Thomson et al., 2016; Hinshaw et al., 2022). More specifically, cannabis, tobacco, and alcohol misuse, depressive and anxiety disorders, chronic pain, insomnia, and poverty are at greater risk in AFABs with ADHD than other AFABs. In a comparative study of these outcomes, prevalence in the ADHD group was double or triple that found in the non-clinical group after age, race and other subject variables were controlled for (Fuller-Thomson et al., 2016). It thus follows that women with ADHD are often subjected to heightened rejection and stigma societally (Young et al., 2020).

Studies corroborate the greater susceptibility in women with ADHD, than men with the condition, to overall impairment. Such impairment is displayed by the lower self-esteem and increased psychiatric comorbidities examined above. Moreover, marital and occupational difficulties also occur more in ADHD-diagnosed women than men (Attoe & Climie, 2023; Hayashi et al., 2019; Smyth et al., 2015). In the occupational sphere, for one, women often experience career indecision, low self-efficacy, and are more likely to work in environments that do not accommodate ADHD than adult males with the condition (Hayashi et al., 2019; Smyth et al., 2015). Thus, gender differences mark an important aspect of ADHD requiring further attention in research.

ADHD Research in South Africa

ADHD is of significant public health concern in South Africa as indicated by statistics associating individuals with the condition with poorer academic attainment, poorer vocational outcomes, and greater health concerns such as increased accidental injuries, motor vehicle accidents, and comorbidities (Schoeman & de Klerk, 2017; Vrba et al., 2016). However, an overwhelming amount of local ADHD research relates to educational spheres, particularly in young school-aged samples. Learning difficulties associated with the condition (e.g., Milander & Schall, 2020), and investigations of set-shifting competencies (e.g., Boshomane et al., 2021), for example, comprise of recent local studies on ADHD learners. While these factors perhaps indicate indirect pathways impacting social functioning, especially considering international literature identifying these as risk factors for detrimental social outcomes (Boshomane et al., 2021), more local research is needed that directly addresses the lived experiences of ADHD populations. More so, more literature on adult ADHD populations is needed locally.

Education Contexts

Of the minimal local studies related to social or interpersonal experiences in youth, many exclusively sampled third parties like parents and teachers. Within the school domain, a mixed-methods master's dissertation was conducted on intermediate phase (grades 4, 5 and 6) teachers across the Western Cape (N=112) and investigated their attitudes towards ADHD learners (Yarde-Leavett, 2018). This study identified that teachers felt under-prepared to adequately manage these learners, in addition to finding them disruptive (when overtly hyperactive) and difficult to teach (Yarde-Leavett, 2018). A similar study on primary school teachers tested their knowledge of ADHD (Topkin et al., 2015). This study found a lack of ADHD knowledge, with only 45% of teachers correctly identifying responses in items, despite the majority (82.2%) having received ADHD-specific training. Considering the substantial amount of time learners spend with teachers, and the important role teachers play in their overall functioning, these findings depict concerning implications for the social and academic outcomes of ADHD youth in the country (Topkin et al., 2015; Yarde-Leavett, 2018).

Familial Contexts

Within the familial domain, local ADHD literature has also similarly primarily garnered third-party accounts. For one, Tancred and Greeff (2015), via a questionnaire and biographical survey given to mothers, investigated the role of parenting styles on coping and adaptation in families with children (aged 6-14, 81% male) that have ADHD in the Western Cape. The study found that the healthiest functioning families were predicted by the mothers' connection and warmth, the mothers' regulation, and the medication usage of the children. This study also highlighted that maladaptive parenting practices were often used in response to the ADHD children's non-compliance (Tancred & Greeff, 2015).

Another study investigated knowledge on ADHD by recruiting parents of children (aged 5-17) with the condition from a clinic in KwaZulu-Natal (Rajcumar & Paruk, 2020). This study found concerning misconceptions in these parents, including believing that reducing sugar and food additives in one's diet (over 90% of parents), and that increased or stricter punishment (over 78% of parents) reduces symptoms of ADHD. Ironically, this 'stricter punishment' contradicts the 'warmth' that Tancred and Greeff's (2015) study found to be indicative of improved family adaption. Withal, as established by several studies, improved psychoeducation on ADHD is needed locally (Rajcumar & Paruk, 2020; Topkin et al., 2015; Yarde-Leavett, 2018).

Lastly regarding familial life, one South African study recruited eight AFAB adults (M_{age} = 20) and interviewed them about having a sibling with ADHD (King et al., 2016). Themes of differential parental treatment and discrepancies in disciplining emerged, where participants felt overlooked and burdened by the significant attention given to their sibling (King et al., 2016). Although something can be inferred about the experiences of the ADHD sibling, more local research is needed to garner direct accounts of the experiences of individuals with the condition.

Direct Accounts of Social Experiences

Two qualitative studies on South African youth were found that garnered direct accounts of life with the condition. The first interviewed four adolescents, aged 13-14, on how they perceive their competence, relationships, and having ADHD overall (Seabi & Economou, 2012). The second study, published five years later, tried to understand the perspectives of people with ADHD and additional role players in their lives, such as professional caregivers and family members (Mahdi et al., 2017). The researchers conducted focus groups and semi-structured interviews with 76 participants in total from five different countries, with most participants being from Sweden (*n*=37), and five being South African.

In the first study, the participants were shown to encounter several problems scholastically as seen via behavioural issues in the classroom, academic difficulties, discord with peers, and stigma from teachers and classmates alike (Seabi & Economou, 2012). While the authors mostly framed the participants' experiences of ADHD negatively, indicating that they had "terrible feelings … as a result of having ADHD" (Seabi & Economou, 2012, p. 176), the direct quotations from the participants did not confirm that they indeed felt this way. Moreover, although their participants indicated positive feelings of self-worth, the authors related this to a notion that children with ADHD have "exaggerated self-perceptions" as a "self-protective mechanism to ward-off feelings of inadequacy and helplessness" (Krueger & Kendall, 2001, as cited in Seabi & Economou, 2012, p. 177). Given that the study was conducted during a period where ADHD was largely seen as a disruptive/behavioural disorder, these findings should be noted with caution. Lastly, a limitation noted by the authors themselves, was that focusing on the school context led to no information on how the participants experience familial life (Seabi & Economou, 2012).

The second qualitative study made a better attempt at gathering holistic perspectives by also eliciting thoughts on the perceived benefits and strengths of ADHD (Mahdi et al., 2017). Of the total sample, 71% noted positive sides to ADHD. Some of these included increased tenacity, ambition, creativity, the ability to hyper-focus, achieving goals and meeting deadlines under pressure, and personality traits such as being accommodating and helpful (Mahdi et al., 2017). However, 15 participants (20% of the sample) felt unable to answer this question, of which 13 were participants with ADHD. Of the seven participants noting no positives, five were concerningly immediate family members of someone with the condition (Mahdi et al., 2017). Thus, seeing that most people reporting no benefits were immediate family members, rather than an 'exaggerated self-perception' (Seabi & Economou, 2012), perhaps these studies indicate that people with ADHD are harshly perceived by people in their life. Howbeit, preliminary local findings on the social experiences of ADHD-youth are worrisome.

Social Impairment in ADHD Populations

Social Experiences in Youth

As per limited research on adults, literature on younger ADHD samples can provide preliminary insight. In some studies, children with ADHD were tested against control groups, noting that ADHD samples had less dyadic friendships and peer acceptance in comparison (Humphreys et al., 2016), that ADHD samples experienced more emotional dysregulation (ED), which correlated with social impairment (e.g., Jaisle et al., 2023), and that ADHD samples experienced more sensitivity to peer feedback, when examining Electroencephalogram (EEG) tests (Babinski et al., 2019). Another study examined the role of depression and emotional dysregulation (ED) as mediators of social skill deficits in ADHD youth, noting that these variables mediated at least a third of the variance of social skills in ADHD youth (Bunford et al., 2015).

However, limitations in sampling and/or study design make it difficult to make indisputable claims about social functioning in ADHD samples. In one study, for example, of the sample of 157 children, five had ADHD while 152 were controls (Russo et al., 2015). Thus, although this study noted that children with ADHD were less assertive, more isolated, and had greater difficulties maintaining bonds with peers, reliability and validity concerns are warranted. What can also be problematised about sampling in ADHD literature is gender bias. Of the studies reviewed in this chapter alone, one had a sample of over 170 youth, with 76% being male (Bunford et al., 2015), another had a sample where 69% were male (Humphreys et al., 2016), and another studied 108 youth, with only 40 being girls (Jaisle et al., 2023).

Social Experiences in AFAB Youth

Studies agree that girls with ADHD often experience more peer victimisation, social rejection, and bullying, and worse friendship quality, peer status, and social competence in comparison to controls (Kok et al., 2016; Young et al., 2020). Retrospectively, women with ADHD reported feeling alienated and different to their peers in childhood, thus also struggling to relate to them (Attoe & Climie, 2023). More so, while the school domain is depicted as especially unpleasant, access to other means of social support are compromised by prevalent discordant relationships with parents and siblings, and heightened stress in the families of girls with ADHD (Hinshaw et al., 2022; Young et al., 2020). It is proposed that they may resultantly compensate for this by trying to gain a sense of belonging via detrimental means, such as by engaging in destructive activities with dysfunctional social groups (Young et al., 2020).

ADHD Symptom Domains and Social Outcomes

Displays of hyperactivity place young AFABs at social risk. In a longitudinal study examining peer problems and ADHD symptom domains, the all-female adolescent sample was uniquely predicted to experience peer problems if they displayed ADHD-H symptoms, whilst ADHD-I symptoms did not yield similar results (Ahmad et al., 2021). Similarly, girls with ADHD-C have been depicted as more likely to experience peer rejection than those with ADHD-I (Hinshaw et al., 2022).

Although, it should be noted that research has yielded mixed findings when examining links between ADHD symptom domains and social impairment. Jaisle and colleagues' (2023) study, conducted on a mixed-sex youth sample, found that ADHD-I was directly predictive of social impairment, whilst ADHD-H samples experienced social impairment via emotional regulation (ER) difficulties. However, the findings of this study may indicate escalated risks for all AFABs with ADHD, as the consensus in research is that females with ADHD struggle with ED more than their male counterparts (e.g., Welkie et al., 2021), and that AFABs are more often diagnosed with ADHD-I than other ADHD subtypes (Young et al., 2020).

Emotions and Social Impairment

Emotions have commonly been investigated in literature, with ED often leading to social challenges and compromised relationships in ADHD samples (Cohen et al., 2021; Jaisle et al., 2023; Wymbs et al., 2021). Although not considered a definite characteristic of ADHD, ED has been said to affect up to 70% of adults with the condition (Edel et al., 2015). ED was also found to be twice as likely to occur in adults with ADHD than comparison controls (Cohen et al., 2021). Additionally, research has demonstrated that emotional insight and ER strategies are impaired in young AFAB adults, but not young AMABs, and that this uniquely links AFABs to comorbid depression (Welkie et al., 2021). Finally, in Bora and Pantelis's (2016) meta-analysis of studies investigating emotional recognition and theory of mind (ToM), the consensus was that ADHD samples lie in-between ASD samples and neurotypical samples with regards to social cognition. From these findings, Bora and Pantelis (2016) suggested that people with ADHD may have inherent social difficulty symptom domains. These authors thus advocated for future studies to further investigate this.

Interpersonal Relationships

To the best of my knowledge, to date, only one qualitative study has directly examined the lived experiences of adults with ADHD regarding their interpersonal relationships. In this study on 43 adults (84% female, 72% White, 86% from North America), Ginapp et al. (2023a) used focus groups to gather data on how the participants felt ADHD affected their relationships, and whether they perceived any benefits to online communities and social media. The participants indicated that they found it difficult to relate to and engage with neurotypical people, that they felt different to neurotypical people, and that they were often misunderstood due to their symptoms being taken personally, thus resulting in conflict. At times their traits were also said to be perceived as unlikeable, such as being considered “too emotional or too talkative and excitable” by others (Ginapp et al., 2023a, p. 4).

Participants in this study also reported feeling invalidated for their ADHD, and that it was not considered an impairing medical condition, so much so that if they explained their difficulties without naming their diagnosis, they were taken more seriously than when attributing these to ADHD (Ginapp et al., 2023a). Similarly, a sense of belonging and community was built with other neurodivergent people, and the participants in this study felt more comfortable interacting with this population. More so, relationships felt easier to maintain with other neurodivergent people due to similar communication styles, such as neurodivergent people being perceived as more direct and tolerant. However, regarding online communication, the participants in this study noted that social media provided a potentially vulnerable platform for further isolation, such as if they were to have different opinions to the general online ADHD community on things like stimulant medication.

More challenges arose with online communication, as noted by the participants in this study. For one, several noted that they preferred face-to-face communication, and that social media was sometimes overwhelming and hard to maintain (Ginapp et al., 2023a). This was due to factors such as failing to maintain consistent contact with others by forgetting to respond, feeling reluctant to post due to rejection sensitivity dysphoria (RSD), and fearing that devices (e.g., phones) in general are a distraction from the completion of daily tasks. A study on Korean university students with elevated ADHD symptoms had similar findings, noting that the freedom and lack of structure of university made it hard for the participants to juggle their responsibilities and keep promises they made to others (Kwon et al., 2018). As such, difficulties with organisation was found to be a mechanism whereby ADHD-related difficulties can negatively affect interpersonal relationships (Ginapp et al., 2023a; Kwon et al., 2018).

Romantic Relationships

Literature has found that couples with at least one ADHD-diagnosed partner are more likely to divorce than others (Kessler et al., 2005, as cited in Smyth et al., 2015). Also, observing doubled divorce rates to controls, are parents of an ADHD child, although literature has failed to explore potential moderators of these outcomes (Wymbs et al., 2021). In their review of literature on romantic relationships and ADHD, Wymbs et al. (2021) noted worrying findings. For one, spouses (96%) of those with ADHD often felt their partners' symptoms interfered in overall functioning, noting household organisation, child-rearing, communication, and time management as concerns. Of these spouses, 92% also explained compensating for their partners' difficulties (Wymbs et al., 2021).

Likewise, studies indicate greater work-life balance difficulties in women with ADHD, often attributed to societal expectations that they be responsible for household and child-rearing tasks (Smyth et al., 2015). Compounding this, the non-ADHD partners of ADHD diagnosed women note more dissatisfaction with their partners' ADHD symptoms than non-ADHD diagnosed women do of their male-ADHD partners (Wymbs et al., 2021). Furthermore, studies indicate that the more ADHD symptoms women exhibit, the more likely they are to experience relationship dissatisfaction (Bruner et al., 2015, as cited in Smyth et al., 2015).

Studies show that people with ADHD likely gravitate to one another, making it common that when one romantic partner had ADHD, the other has marked ADHD symptoms (Wymbs et al., 2021). As such, it becomes relevant that men with a childhood ADHD diagnosis are found to perpetrate intimate partner violence (IPV) more than controls, which potentially makes women with ADHD vulnerable to victimisation (Wymbs et al., 2021). A longitudinal study on girls with childhood ADHD similarly noted that by adulthood they were more likely to have been victims of IPV than controls (30.7% vs. 6.3% respectively; Guendelman et al., 2016). Overall, Wymbs and colleagues (2021) determined that research suggests women with ADHD experience more romantic relationship difficulties than men with the condition. It is thus unsurprising that women with ADHD are also shown to have less romantic partners in their lifetime than controls (Wymbs et al., 2021). Nonetheless, studies primarily examine heterosexual relationships (Wymbs et al., 2021), and it is possible that heteronormative standards may partially explain some of these findings. As such, more diverse samples warrant further investigation.

Relationship Barriers Specific to ADHD

Studies interviewing ADHD-diagnosed adults perhaps contextualise some of the findings of Wymbs et al. (2021). For one, Ginapp and colleagues' (2023a) participants noted that their relationships were threatened by logistical difficulties, such as not keeping living spaces tidy and not keeping time. Another qualitative study similarly found that ADHD symptoms resulted in interpersonal difficulties due to struggles with punctuality, forgetfulness, and interrupting or being inattentive in conversations, amongst others (Canela et al., 2017). One way participants tried compensating was to make considerable efforts to remain punctual or buffer similar difficulties. On the other hand, participants also noted avoiding commitments or being needed by others altogether to prevent these interpersonal difficulties.

Other studies similarly show that AFAB adults with ADHD report caution in relationships and are distant or find it difficult to be vulnerable with others (Attoe & Climie, 2023). Literature has also found that people with ADHD-H often feel restricted around new people out of fear of negative evaluation (Greenberg & De Los Reyes, 2022). This is due to their externalised traits potentially being considered off-putting by others, resulting in greater experiences of social rejection for those exhibiting these (Greenberg & De Los Reyes, 2022). Individuals with ADHD are also suggested to exclusively try forming relationships with people with similar traits, who are considered likely more accepting (McKeague et al., 2015). In one study, retrospective accounts of external stigma in childhood resulted in selective disclosure of their diagnoses in young adults with either ADHD or major depressive disorder (MDD; McKeague et al., 2015). Overall, this study found that past treatment from others correlated with either developing self-stigma in adulthood, or building resilience to future stigmatising interactions. However, this study only used participants who were diagnosed with one of the two conditions, thus negating the voices of a considerable demographic of adults who have both comorbidly.

Ginapp et al. (2023a) noted that adults with ADHD explained generally struggling to maintain long-term relationships. At times this was due to struggling to keep in touch with others, and other times due to craving novelty, leading to often forming new bonds and neglecting former ones. Kwon et al. (2018) similarly noted that their study participants felt unable and/or reluctant to express negative emotions to others, and would go as far as avoiding certain situations or people altogether to prevent needing to. There were also themes of difficulties with conflict resolution, where participants suppressed their negative feelings and coped via denial or trying to downplay their troubles.

Lastly, experiencing RSD is agreed to likely impair social relationships (Bedrossian, 2021; Dodson, 2023; Ginapp et al., 2023b). Although rejection sensitivity is sometimes discussed in relation to mood, anxiety and personality disorders, RSD names an intense and relatively short-lived (a few hours at most) emotional response to real or perceived rejection that is uniquely linked to individuals with ADHD (Dodson, 2023; Littman, 2023). Almost all ADHD-diagnosed adults are proposed to struggle with RSD, and it is considered a component of ED (Bedrossian, 2021; Dodson, 2023). As such, while environmental factors like childhood rejection might aggravate it, RSD is understood to demonstrate characteristic differences in ADHD brains that physiologically predispose those with the condition to it (Dodson, 2020). RSD can lead to people-pleasing, social-withdrawal, self-isolation, harsh self-evaluation, emotional reactivity, and aggression (Bondü & Esser, 2015; Dodson, 2020, 2023). ADHD-diagnosed adults have also reported avoiding loved ones whom they anticipate rejection from, thus noting RSD to compromise the longevity of their relationships (Ginapp et al., 2023b). Therefore, literature depicts RSD to be one of several risks for hampered relationships in ADHD-diagnosed individuals.

Concluding Overview

This review provided a synopsis of current knowledge on the lived experiences of ADHD populations. Adults with ADHD are known to be at risk of several detrimental outcomes regarding their physical, social, and mental well-being. University students and AFABs are particularly vulnerable sub-groups of this population. Seeing how ADHD symptoms often differ in AFABs and adults, and how IG complicates ADHD recognition (see Chapter 1), exacerbated mental health risks exist for AFAB tertiary students. Possibly reinforced by the under-recognition of ADHD in them, it is concerning that not enough research exists on this demographic. As such, future research should bridge this gap.

Similarly, current literature on the social experiences of ADHD populations is primarily on young samples. This review examined factors often associated with worrying social outcomes in ADHD samples, such as externalised/hyperactive traits, which research suggests present differently in AFABs and adults. More so, the term ‘social impairment’ encompasses, across studies, innumerable experiences not limited to bullying, less assertiveness, and peer rejection. This broad definition has led to a limited understanding of the detailed and nuanced social experiences of ADHD populations. Furthermore, the term demonstrates countless variables that have implications on interpersonal relationships. Thus, more ADHD literature specifically investigating interpersonal relationships is needed.

Studies examining social outcomes in ADHD also necessitate discernment when interpreting their results. For one, demand characteristics and confirmation bias potentially implicate the validity of frequently observed research designs, where sampling bias and/or third-party ratings prevail. Even in studies using self-report measures, the potential for skewed reporting exists (Johnston et al., 2012). Thus, the predominantly quantitative findings discussed in this review may reflect some of these concerns.

Likewise, literature has linked social impairment in ADHD to a number of variables, including depressive symptoms and ED. Considering the complexities associated with ADHD, such as a heightened likelihood for comorbidities, some studies have potentially inadequately accounted for these as potential mediators, as discussed in Wymbs and colleagues’ (2021) review. As such, researchers’ attempts to yield reliable and generalisable results may fall short. Considering these factors, future studies qualitatively investigating the interpersonal relationships of ADHD populations are warranted. Research is especially needed to better understand this phenomenon in under-researched ADHD populations, such as AFAB adults.

This chapter provided a literature review on the social experiences of ADHD-diagnosed individuals, showing that not enough is qualitatively understood about their interpersonal relationships. This was shown to be especially true in the South African context and for under-diagnosed demographics like AFABs and university students. The following chapter will present my methods.

CHAPTER 3: METHODS

This chapter details the methods used to conduct this study. I first present the research questions and the theoretical framework that informed my study design, sampling, and data collection methods. This is followed by a chronological account of the procedures followed from participant recruitment to data analysis. I then note my ethical considerations and discuss my quality assurance and rigour practices.

Research Questions

I sought to address the identified gaps in ADHD literature as per the following research question: How do AFAB adults with ADHD experience interpersonal relationships?

I was further guided by the following sub-questions:

i. How do the participants navigate interpersonal relationships considering their unique experiences of being university students with ADHD in South Africa?
ii. How might the participants perceive having ADHD as having influenced their interpersonal functioning (e.g., forming new connections, maintaining relationships, managing social demands, etc.)?

Theoretical Framework

Phenomenology is the study of lived experiences (Tuffour, 2017). As such, it is concerned with understanding a phenomenon under the lens of how it is experienced by individuals. Two predominant branches of phenomenology are Husserl’s transcendental (or descriptive) phenomenology, and Heidegger’s hermeneutic (or interpretive) phenomenology. The former is concerned with discovering a ‘universal’ truth (Willig, 2013), in which researcher bias is ‘bracketed’ and commonalities in lived experiences are extracted to expose the ‘essence’ or ‘truth’ of a phenomenon (Neubauer et al., 2019). In other words, this approach attempts to garner and describe a single and supposedly objective reality. However, Heidegger’s hermeneutic phenomenology, in response to Husserl’s, argues that a pure description of one’s lived experience cannot be achieved, and that in description alone, interpretation (and thus subjectivity) is inevitable (Willig, 2013). More so, this branch of phenomenology is grounded in its acknowledgement of an individual’s context as pertinent to their lived experiences (Tuffour, 2017). This means that multiple realities, as informed by the unique circumstances and subjective perceptions of different individuals, are said to exist. These realities are thus equally relevant and important.

Interpretive phenomenology is ontologically relativist and epistemologically subjective (Chen et al., 2011). A relativist ontology understands that reality is socially constructed and hence influenced by continuous and bi-directional interactions between an individual and their context (Braun & Clarke, 2013; Ryan, 2018). Epistemological subjectivity and interpretivism argues that a single, factual, or unbiased account of 'reality' cannot be fully accessed and likely does not exist (Braun & Clarke, 2013; Willig, 2013). Thus, interpretive phenomenological researchers are tasked to immerse themselves in the participants' experiences and see their worlds from their unique perspectives (Chen et al., 2011).

Generating knowledge about participants' experiences is understood as inherently embroiled in cyclical interpretive processes (Willig, 2013). Hermeneutic phenomenology acknowledges that "understanding cannot take place without us making some preliminary assumptions about the meaning of what we are trying to understand" (Willig, 2013, p. 258). Moreover, hermeneutics denotes that experiences can only be understood as situated within a broader context, and that understanding this broader context is also dependent on understanding the specific experiences within it. As such, a 'hermeneutic circle' ensues where meaning is garnered via these perpetual interpretations of specific and broader experiences and contexts (Schleiermacher, 1998, as cited in Willig, 2013). Furthermore, while participants are involved in interpreting their own experiences, a researcher is involved in interpreting the participants' interpretations, resulting in a 'double hermeneutic' (Smith & Osborn, 2008). As such, interpretive phenomenological studies understand that the researcher's interaction with the data is essential to meaning-making (Willig, 2013). Consequently, researcher subjectivity inherently influences the research. To mitigate this, researchers should thoroughly interact with the data to modify their initial assumptions and get closer to the participants' lived experiences (Willig, 2013). More so, researcher reflexivity is especially important (Willig, 2013).

Interpretive phenomenology was the most suitable framework to address my research aims and questions for several reasons. For one, its hermeneutic approach to meaning-making was useful in guiding me to gather nuanced and detailed understandings of the participants' experiences, as informed by their contexts. Understanding context as per interpretive phenomenology, however, also required me to have an empathic approach (Willig, 2013). This is because rather than being concerned with objective 'truths', I was concerned with understanding the participants' subjectivities. Thus, rather than "arguing with" (Braun & Clarke, 2022, p. 20) the participants interpretations, I instead made “sense” of these by generating “knowledge about the quality and texture” of their experiences (Willig, 2013, p. 74). This was essential given the noted limitations in existing ADHD literature, where the perspectives of AFAB adults with ADHD are insufficiently understood. As such, an interpretive phenomenological framework allowed me to prioritise and centre the participants’ unique subjectivities.

Study Design

This study followed a qualitative research design, specifically within the ‘big Q’ approach which favours inductive methods (Braun & Clarke, 2013). I furthermore used an interpretive phenomenological framework to generate rich and detailed accounts of the participants’ experiences. Qualitative research is concerned with the subjective experiences of participants, making it especially useful for under-researched topics in marginalised populations (Braun & Clarke, 2013; Tuffour, 2017). The inductive method of knowledge generation in this ‘big Q’ approach requires that researchers be empathic, receptive, and flexible, in order to gather unanticipated and detailed insights (Willig, 2013). With the noted gaps in ADHD literature, it was important to adhere to an approach that values the participants’ perspectives above all else.

I was furthermore guided by Braun and Clarke’s reflexive thematic analysis (RTA; Braun & Clarke, 2022). Braun and Clarke (2022) note that RTA details “a “deep” process of reflexive interrogation of researcher assumptions and practice, rather than a simple listing of identity or experience categories when reporting research” (p. 9). My recognition of the intrinsic researcher subjectivity within my study design justified my use of RTA as it guided the acknowledgement and management of my subjectivities so that they did not compromise my research quality. The methodological choices that I made, as informed by RTA, are noted throughout this chapter.

Sampling

Qualitative research is characterised by small participant numbers (Willig, 2013). Sample size should be small enough to allow researchers adequate time to fully engage with the data (Chapman & Smith, 2002). Braun and Clarke (2022) however recommend that sample size be a combination of practicality and utility. For diverse populations, larger samples can help researchers obtain a range of perspectives that better reflect the diversity in experiences (Braun & Clarke, 2022). Furthermore, given that RTA requires meaning to be generated across data sets, larger participant numbers assist with theme generation (Braun et al., 2016; Braun & Clarke, 2022). Considering these factors, 12 participants were deemed reasonable. Table 1 depicts the participant demographics.

Table 1

Participant Characteristics

Pseudonym	Age	Race[4]	Pronouns	Years Diagnosed
Amy	22	White	She/her	1-2
Anele	18	Black	She/her	Less than 1
Anika	31	Indian	She/her	1-2
Charlie	19	White	Any	10+
Clare	23	White	She/they	10+
Jemma	21	White	She/they	5-6
Lena	20	Coloured	Any	Less than 1
Nadia	22	Indian	She/her	Less than 1
Palesa	23	Black	She/her	2-3
Priya	21	Indian	She/her	Less than 1
Tanya	19	White	She/her	10+
Toni	24	Mixed race	They/them	10+

Note. ‘Years diagnosed’ refers to this period at the time of the interview.

Most participants were undergraduate students, and three were completing postgraduate degrees. Seven participants were cisgender while the other five were gender diverse. Three participants were not South African by origin, but all 12 grew up in the country. Regarding potential comorbidities, 11 participants were previously diagnosed with depression and anxiety, with most in remission, and one believing the diagnoses to be a misdiagnosis for their ADHD. One participant also felt misdiagnosed with borderline personality disorder, and another with dyslexia, in place of their ADHD. Although not formally diagnosed, six participants felt socially

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[4] Distinguishing participants according to this variable sometimes sparks controversy due to the history of racial segregation in South Africa. However, the legacy of apartheid perpetuates and thus race continues to impact the experiences of people in the country, as highlighted by social scientists (Young & Campbell, 2014). The participants’ respective self-identified race was thus considered an important demographic to document.

anxious. Another three suspected comorbid ASD, with two being assessed for the condition, and the third being self-diagnosed. Two participants had a history of disordered eating, another two had a history of post-traumatic stress disorder, and another struggled with substance misuse. Lastly, one participant indicated potentially having comorbid bipolar II disorder. Regarding medication, two participants were no longer taking any, seven were taking only stimulants, one was taking both stimulants and anti-depressants, and two were taking only anti-depressants.

Purposive, convenience sampling was used to recruit individuals who met the following criteria: adult, student at UCT, ADHD diagnosis from a qualified professional, AFAB. Purposive sampling was essential, as only the specified demographic could provide relevant insight on my topic of interest. Convenience sampling was observed by recruiting only UCT students, which offered practicality given my time and resource constraints. Finally, the specificity of my participation criteria offered me a relatively homogenous sample, which is useful for theme development in RTA (Braun & Clarke, 2022) and recommended for interpretive phenomenological enquiries (Chapman & Smith, 2002).

Data saturation, or the point in qualitative research where the data gathered is considered substantial for researchers to develop theories (Morse, 1995), was not relevant to this study. This is because it is epistemologically incompatible with my study design. For one, it suggests an ‘endpoint’ in data collection and presumes that the phenomenon in question has been fully investigated (Braun & Clarke, 2022). This denotes a positivist stance that negates the existence of multiple realities and the infinite potential to garner new insights, as per hermeneutics, interpretive phenomenology, and RTA.

Data Collection

This research project was a collaborative study on the experiences of AFABs with ADHD. The researchers were myself and my classmate, Estelle Prinsloo. We both had Dr Maxine Spedding as our supervisor. While my study was concerned with the participants’ experiences of relationships, Estelle’s was concerned with their experiences of camouflaging. We each conducted six semi-structured interviews that lasted between 50 and 120 minutes. Semi-structured interviews allow enough flexibility for the participants to “speak freely”, and thus feel comfortable, while also “ensuring that the interviewer does not lose sight of the original research question” (Willig, 2013, p. 107). This justified using this approach. The interview schedule (see Appendix C) was jointly written to address our respective topics.

The beginning of the interview invited shorter contextual responses, such as identifying a timeline of how and when the participants were diagnosed with ADHD. The latter part of the interview had more open-ended questions on the subjective experiences of the participants, with probes for clarity if needed. It is recommended to structure qualitative interviews in this manner, as contextual questions offer participants time to warm up to the researcher, and thus assist with rapport building (Willig, 2013).

Procedure

Recruitment

Ethical clearance from UCT's Department of Student Affairs (DSA) was first obtained in order to use UCT students as participants. The DSA distributed our participation advert (see Appendix B) to the email addresses of students currently registered at UCT. This advert was accompanied by written text, in the body of the email, specifying what the study was about, who the researchers are, that the study formed part of the requirements of a Clinical Psychology degree, that ethical clearance had been granted. The email also provided my student email address for interested participants to contact me on.

Upon receiving emails from prospective participants, I responded by sending the study information sheet. Those still interested were emailed the informed consent form (see Appendix A). I informed the first six to confirm that they would be contacted by Estelle to finalise interview logistics, and then arranged personal interviews with the next six. The remaining respondents were informed that participation was full. All communication was done in English and no language barriers occurred.

Interviews

Most interviews took place in-person at the UCT Child Guidance Clinic (CGC) to allow for privacy, convenience, and audibility. One participant had her interview over a Microsoft Teams video call. Participants were aware that we would provide hard copies of the informed consent forms upon arrival at the clinic. For the Teams interview, the participant sent me a digitally signed consent form prior to the interview.

Upon meeting, the interviewer re-introduced the study and then allowed participants to ask questions. Demographic information was also gathered. The interviewer then begun audio recording on two devices to buffer against unforeseen circumstances. The interview recordings were immediately (same day) transferred to a password-protected folder on UCT One Drive that only Estelle and I had access to. They were thereafter permanently deleted from the recording devices.

The audio recordings were used to transcribe the interviews via the Microsoft Word ‘transcribe’ tool. Estelle and I then edited the transcripts to ensure they were verbatim and error free. We transcribed our own interviews as the physical gestures (i.e., non-verbal cues) that we observed from the participants were used as contextual/explanatory notes in the transcripts.

After transcribing, Estelle and I individually compiled a document, for each participant, that comprised of a summary of how we understood their experiences (i.e., member-checking). Each then received the documents (i.e., two per participant) via email, and was asked to comment on whether we accurately understood them. At times, clarification questions were also added to these documents. We gave the participants two weeks to return the documents, and all did. The insights received here were used to continue and refine data analysis.

Data Analysis

Thematic analysis is the broad term for several methods that allow researchers to synthesize units of textual meaning and find commonalities and differences (Nowell et al., 2017). My chosen thematic analysis approach was RTA (Braun & Clarke, 2022). This model involves a flexible adherence to the following six-steps: (1) data familiarisation, (2) code generation, (3) theme generation, (4) reviewing themes, (5) finalising themes, and (6) producing the final report (Braun & Clarke, 2006). These steps are flexible due to the likelihood of a frequent and non-chronological oscillation between them when applied (Braun et al., 2016).

For me, (1) data familiarisation consisted of transcribing the interviews and compiling the member-checking documents. I also frequently listened to the interview recordings. Next, (2) I manually annotated the transcripts, using NVivo, by adding latent (i.e., implicit meaning) and semantic (i.e., explicit meaning) codes besides relevant passages (Braun et al., 2016). This manner of thorough engagement with the data is recommended in RTA, and Braun et al. (2016) advise that researchers “‘go beyond the obvious’, and capture the messy, contradictory and complex nature of psychological and social meanings” (p. 17).

Following coding, (3) I synthesized the codes to generate initial themes. I then continued (4) reviewing, re-naming and redefining these themes to check that they were adequately differentiated and substantiated. This step is particularly useful as RTA rejects “underdeveloped” themes in favour of more “compelling” and “nuanced” ones (Braun & Clarke, 2022, p. 9). After oscillating between these steps, (5) I finalised my themes and (6) presented my findings in this report.

Ethical Considerations

This study obtained ethical clearance from the following UCT review boards: the department of Psychology's ethics review committee, the faculty of humanities' research ethics committee, and the DSA (see Appendix E). Throughout the research process I also abided by the regulations stipulated in Annexure 12 (i.e., Rules of Conduct Pertaining Specifically to the Profession of Psychology) of the Health Professions Council of South Africa (HPCSA) Form 223 of 2006 (HPCSA, 2006).

Informed Consent

The researchers disclosed the study purpose, overarching research questions, and what participation would entail, both verbally and via informed consent forms (see Appendix A) that were signed before data collection. Participants knew that they can withdraw from the study at any stage without negative repercussions. They were also provided with details of who to contact should they have queries/concerns.

Confidentiality

Pseudonyms were allocated to each participant and all identifying information was redacted in the transcripts and all subsequent writing. The participants consented to their demographic information being used and knew that the final report would be disseminated.

Data Management

A detailed data management plan (DMP) was registered on the UCT DMP website. The plan entailed that the researchers will not upload any original data files to any of UCT's repositories. The interview recordings and transcripts were only accessible via the protected One Drive folder. All transcription also occurred on this platform via Microsoft 365. The recordings were permanently deleted after transcription was complete. The anonymised transcripts remain securely located in this folder.

Risks and Benefits

Participation in the study held some risk due to the personal nature of the interview questions. Participants were free to choose not to answer every question and could also stop the interview at any time without consequences. While there were no guaranteed benefits to participation, the prospect of winning a R500 Takealot voucher was considered reasonable compensation.

Both Estelle and I used our lay counselling experience to make the participants comfortable and to assist with the verbal debriefing done after each interview. We also consulted with our supervisor accordingly. All the participants were sent a debriefing form and resource list (see Appendix A) for further support.

Vulnerable Groups

Willig (2013) notes that "while higher levels of interpretation enrich the research by generating new insights and understanding, they also give rise to ethical issues around the imposition of meaning and giving/denying voice to research participants" (p. 275). Although, Braun and Clarke (2023) express the incompatibility of RTA and "realist/positivist quality practices, like saturation… and member checking", they acknowledge the ethical importance of member-checking in "socially marginalized groups" (p. 4). Hence, conducting member-checking was an ethical practice that was deemed more important than strictly adhering to RTA, especially considering the social vulnerability of this study's sample.

Rigour

Sound research practices are of ethical importance. Where quantitative studies use 'reliability' and 'validity' to ensure research quality, 'rigour' is referenced in qualitative studies (Cypress, 2017). Rigour is defined as the quality of meticulousness and precision in qualitative research (Cypress, 2017). The 'TACT' framework, adapted from Lincoln and Guba's (1985, as cited in Daniel, 2018) guidelines, was used to ensure rigour in my study. This framework derives its name from the following four dimensions: trustworthiness, auditability, credibility and transferability (Daniel, 2018). Trustworthiness speaks to the overall quality of qualitative research; auditability is the extent to which decision-making is traceable; creditability is how accurately the reported findings reflect the views of the participants; and transferability relates to the extent to which study findings can be applied to other contexts (Daniel, 2018; Nowell et al., 2017).

Auditability was addressed throughout this chapter where I explicitly explained and justified my methods. I furthermore provide examples of my coding and interpretive practices (see Appendix D), in addition to using direct quotes from the participants to substantiate my analysis (see Chapter 4). Credibility was addressed via member-checking. Transferability is achieved by providing rich descriptions of the participants and their contexts (Cypress, 2017), by detailing the nuance surrounding their experiences (Nowell et al., 2017), and by acknowledging the existence of multiple realities (Daniel, 2018). I thus adhered to these guidelines. Finally, trustworthiness was achieved via my reflexivity. I kept a journal documenting my feelings and observations in all stages of the research process, and made sure to ‘own’ my subjectivities in this report (Braun & Clarke, 2022; Willig, 2013). A summary of my pertinent reflections are detailed next.

Reflexivity

Participant Interactions. Being in my mid-twenties, I mirrored a demographic that the participants are surrounded by at UCT and likely see as peers. Estelle being in her late thirties made her visibly older than the participants. Nonetheless, we both noted that all the participants seemed comfortable with us. I believe this is largely due to us disclosing our ADHD diagnoses to them, in addition to them knowing we are fellow students at the same university. Estelle and I both also disclosed our gender identity and pronouns, and shared examples of our own experiences, if needed, to assist with clarification and sense-making during the interviews. These instances of self-disclosure visibly helped build rapport.

I am however cognisant of the fact that Estelle and I doing our master’s in clinical psychology involves an inherent power differential. This is both due us being the researchers, thus being the ones reflecting the participants’ experiences, in addition to our theoretical background further intensifying our potential to impose meaning. Many of the participants disclosed having had unpleasant experiences with health professionals in the past, and thus our status as trainee clinical psychologists may have been intimidating. Nonetheless, I saw most of the participants as peers and felt a sense of comradery due to our mutual neurodivergence. From our interactions, I suspect most reciprocated these sentiments.

The participants of colour spoke about ethnicity and culture as influencing their lived experiences in some instances. Estelle wrote in an interview transcript that, from observing the tone and non-verbal cues given by one participant, there seemed to be hesitation when mentioning her race as potentially influencing her negative experiences. Thus, me being black, and Estelle being white, may have influenced how comfortable different participants felt to speak freely. Lastly, some participants explained experiencing social anxiety in unfamiliar settings. As strangers to the participants, it is possible that this may have influenced how comfortable they felt with us.

Personal Disclosures. Having been diagnosed with ADHD at 23, and with ASD at 26, I am extremely passionate about diversifying research on neurodivergence in AFAB communities. This passion was intensified by the influx of emails I received, within minutes of the study advert being disseminated, from over 70 interested participants. Thus, even before data collection, I felt an overwhelming sense of responsibility to do this study justice.

Although both an 'insider' and an 'outsider' to the participants in different ways, I noticed myself feeling most worried about my 'insider' perspective as someone who also has ADHD. This is because I wanted to ensure that my personal experiences were not preventing me from adequately understanding the participants'. While I recognise that RTA celebrates researcher subjectivity (Braun & Clarke, 2022), my sense of responsibility made me meticulous in verifying that I had a well-rounded understanding of the participants' experiences, thus influencing my decision to conduct member-checking.

Seeing how previous ADHD literature has primarily painted the social experiences of people with the condition in a negative light, I noticed my subconscious desire to produce findings that advocated for our needs better or assigned the blame differently. As such, introspection allowed me to see when I felt protective of the participants and when this impeded my understanding of their personal appraisals. I recognise my background in psychology as also influencing this. This is due to my inclination to sometimes view their thoughts as 'distortions' (e.g., perfectionism), which was counterproductive in my pursuit of empathising. As such, I paid careful attention to mitigate this.

I also recognise that my background in psychology influenced more than just my analytic procedures. In reflecting on our interview schedule, I noticed that the demographic questions focused a lot on gathering information on symptoms and comorbidities. While this was relevant to contextualise their experiences, I also recognise that this predisposed me to making sense of the participants' experiences in an almost quantitative or directional manner. For example, 'x' symptom impacted 'y' experience. I was however able to address this initial bias, especially with the guidance of my supervisor, to better gather a more nuanced understanding of the multiple interactions contributing to the participants' lives. As such, I believe my personal identification with the participants was ultimately a strength rather than a hindrance.

Lastly, my generally left-wing and intersectional worldview likely influenced my research process. In my own life, not only has being AFAB been incompatible with my hyperactive ADHD traits but being black also meant that I felt further subjected to potential stigma from being perceived as ‘too much’, ‘angry’, and ‘aggressive’ due to racial stereotypes. Due to my own sensitization to my socio-economic positionality, I likely similarly interpreted the participants’ experiences under this lens.

Summary of Chapter

This chapter highlighted how RTA (Braun & Clarke, 2022), as informed by an interpretive phenomenological framework, informed my sampling, procedures, data collection and analysis, ethical considerations, and rigour practices. I also provided my reflexivity. The following chapter will detail my findings.

CHAPTER 4: FINDINGS

In this chapter I will narrate the participants' experiences of relationships as organised into two overarching themes. The participants' feelings will be described as explained by them. Direct quotations will also be provided as evidence.

Themes

Table 2 shows the two themes I generated from the data. Each is divided into sub-themes.

Table 2

Themes and Sub-themes

Themes	1. Compromised connection and vulnerability	2. Strategizing to find connection
Sub-themes	1.1 Vigilance of others' perceptions	2.1 Self-monitoring and compensation
	1.2 Feeling judged and misunderstood	2.2 Seeking validation in achievement and likeability
	1.3 Rejection sensitivity	2.3 Disclosing ADHD diagnosis
	1.4 Navigating neurotypical norms	2.4 Finding similar people

1. Compromised connection and vulnerability

This theme depicts several mechanisms that the participants reported prevented them from feeling close to loved ones. The participants expressed feeling hypervigilant about how they are perceived. They described often feeling misunderstood and thus trying to adapt their behaviour to limit hurtful encounters. Furthermore, the participants highlighted that their rejection sensitivity has currently or historically made it difficult for them to assert boundaries and behave freely around others. The participants further highlighted that neurotypical norms often lead them to tailoring their behaviour. All of these factors led to participants feeling cautious, frustrated, alienated, and guarded around others. Consequently, they described these as compromising their ability to develop and maintain close relationships.

1.1 Vigilance of others' perceptions. All the participants expressed being cognisant of how they are perceived and of how their behaviours are potentially impacting others. The participants explained that despite knowing that their behaviours were often ADHD-related, their attention to how others viewed their behaviours impacted their relationships. For one, the participants explained that sometimes, they tailor their behaviour to suit what they feel is expected of them. They expressed feeling that this vigilance often impeded their ability to feel free around others. For one, Toni recalled growing up and feeling like their family often attributed their behaviours to a perceived attitude or personality flaw:

> I think growing up I just always felt that there was something wrong with me. I was the crazy one, all of these things. … [But] I was just neurodivergent and all I needed was a little help … [and] patience from the, the grown-ups in my family … because instead of understanding that I was neurodivergent, people would immediately assume, "She's lazy. She's impulsive. She just does what she wants". (Toni, 24)

Toni reported feeling that, in retrospect, they deserved more support and understanding. Nonetheless, at the time, others' negative reactions to them made them vigilant of how their behaviours were being perceived. Toni consequently wondered if something about them warranted the differential treatment. Similar sentiments were expressed by all the participants.

Participants also reported worrying about others' perceptions of their difficulties with time management and general executive functioning. For one, Anika divulged the following:

> … you get perceived as flaky, for changing plans, but actually, like, when it comes to the moment, you really just can't. … and very often, it's a situation of my own making, where I'm extremely stressed, because it's, like, an overdue deadline … like, I'm just really behind. And so, because of that, then I end up, you know, kind of overcompensating … (Anika, 31)

Other participants also reported "overcompensating" to avoid being misunderstood as "flaky", for instance. They expressed generally going to great lengths to avoid inconveniencing loved ones. For one, the participants mentioned feeling that their enthusiasm in conversations might negatively impact others:

> It's, like, also when people are talking, I end up interrupting them a lot and it's just because I want to let them know that I relate … but, it ends up being me, just, you know, taking the conversation and not letting them speak. (Nadia, 22)

> Mostly with my hyper fixations … I think, that was probably something where people were like, “Okay, you’re killing me. You can stop talking”. … I think my friends were really understanding that I had a lot of passion. … But … they would have thought it … (Lena, 20)

As seen in the above quotes, participants felt that even if others do not outwardly express annoyance over their talkativeness, they worry about whether they are ‘taking over’ conversations or inadvertently boring loved ones.

The participants also explained thinking that others do not fully grasp their self-regulation methods. As such, they understood these methods, such as needing alone time, to be negatively affecting loved ones:

> … I gave my parents a lot of grief. … I was difficult. … on holiday, like, I would run away, uhm, just to be by myself. … I am a person that, like, likes to be by themselves, and need to recharge. … sometimes I would feel like their company would be too overwhelming. (Jemma, 21)

Jemma explained that although she often needs to recuperate by being alone, she thinks this tendency was distressing to her family members. She, like other participants, noted that loved ones often got upset over their periods of self-isolation. Loved ones were reported to either feel neglected or to perceive these moments of “recharge” as rebellion or defiance.

The participants also enlightened feeling like they have complex needs. As such, they reported often trying to be self-reliant:

> I mean, like, previously I would need people to remind me to eat lunch. So, it’s only been the last few years which I’ve been able to train myself to eat. … cause, if I didn’t, don’t, eat, then I get completely emotionally dysregulated. (Clare, 19)

> … and like, only at the last resort, if something's really bad, will I, especially with my family, tell them, what's going on. Uhm, because they're far away, I don't wanna worry

> them, and like … I think it's kind of, it is something that I struggle with … like, feeling like I'm being a burden, like, ja, "Anika's having problems again". (Anika, 31)

Many participants apprehended feeling more high maintenance than perhaps neurotypical people. One such reason was that they saw their emotions as "extreme": "I'm easy to cry. I'm easy to hurt. I'm easy to anger" (Toni, 24); "I feel, like, I have, like, extreme emotions … Like, I feel stuff, like, with intense, intensity" (Tanya, 19). Thus, some participants tried to relieve others of the perceived "burden" of supporting them. Amongst other behaviours, the participants realized that this led to sometimes downplaying or hiding their feelings. Ultimately, this was intended to be out of consideration for loved ones' well-being.

1.2 Feeling judged and misunderstood. The participants described feeling that their relationships suffered due to their ADHD being misconstrued. They reported feeling judged, invalidated, and unseen by loved ones due to these misunderstandings. For one, Palesa recalled a conversation where she tried to seek advice from her family. She expressed that she now refrains from doing so, as she believes they see her struggles as a mindset problem:

> … [I said], "You know, I really struggle with, like, pro– not procrastination, like, just [to] get stuff done". And then [they were] like, "Just tell yourself to do it". And I was like, "*Wow. I never thought of that. Oh, great. All my problems are solved!*"[5]. (Palesa, 23)

Like Palesa, the participants expressed often feeling like advice from loved ones negates the severity of their struggles. They elucidated feeling invalidated by the insinuations made in their loved ones' responses to their concerns:

> … it'll be like, "Oh, like, have you tried writing lists?", and it's, like, "Yes, and I've actually, written seven lists, and I'm still really struggling to do this". … it's like, "If the solution was to write a list, then … there wouldn't be a need for a diagnosis, and I wouldn't need to be taking, like, 54 milligrams of Neucon every day" … (Amy, 22)

As described by Amy, and agreed upon by the other participants, they felt frustrated after being given "tone-deaf" advice. The participants felt these simplistic tips indicated loved ones

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[5] The italics indicate the sarcastic tone the participant used while saying these words.

not fully understanding their ADHD, and not understanding the participants by extension. This was thus explained to discourage the participants from opening up, as they wanted to avoid the feelings of hurt that accompanied these interactions.

Similarly, differences in academic functioning made the participants feel misunderstood by peers, at times even causing tension:

> … the way my other friends are. They, like, the way they can work … and then, they look at me. I don’t know, I, maybe they don’t think this, and maybe this is just me overthinking it, but, like … they can get this done, why can’t I? (Nadia, 22)
>
> … I had a couple of friends in school, who I’d work with, and … they would think that I don't work hard. … I can acknowledge that … I try and work smart, and not hard, um, but it was also just like … the level at which they achieved was, like, worth more than mine, because I worked … in a different manner to how they did. … it's like, “Oh, you only got this mark because of me”. (Priya, 21)

Nadia noted that she sometimes suspects her neurotypical friends judge her due to her difficulties with meeting academic deadlines. Similarly for Priya, she detected her friends getting upset that she would do homework faster than them yet get equally high marks. Priya mentioned working “smart” by taking shortcuts to accommodate her difficulties in sustaining attention. However, she noted that her peers saw this as her not being as hard-working as them. She further explained that they misunderstood her body-doubling efforts, and they used these to try take credit for her grades. Likewise, all the other participants expressed that their different academic functioning was often a barrier in relationships with peers.

Several participants also explained that their families sometimes fell short of understanding their mental health. The participants of colour, in particular, often identified their families’ worldview as limiting their capacity to show adequate support or compassion towards their mental health status:

> … my dad … didn't see it as a real thing. Like, sometimes, at his sermons, he would, indirectly, like, speak to me … and say, like, “Maybe the reason why [you] have depression is ‘cause [you] don't pray hard enough”, or, “It's just an excuse for you to be

> lazy”. So, even though my dad thought what he was saying was helping, it wasn't … (Anele, 18)

> … with the older generation … it wasn't a widespread thing to be diagnosed. … Especially with my family, you know, they're coloured, so … during Apartheid … they didn't have … support. … like I said, I think my mother might be ADHD. … [but she] would have been told differently how to manage it. … they were told to internalize … (Lena, 20)

However, the participants mentioned feeling unsure of whether their family members do not realise how hurtful their words and/or actions are to them. Consequently, the participants expressed coming to terms with loved ones’ beliefs, although these often invalidated their mental distress. As such, they explained selectively deciding if and when to rebut their loved ones’ sentiments.

All the participants mentioned that their symptom severity was often undermined. Although diagnosed in early childhood, Tanya explained feeling like her ADHD was often “dismissed by a lot of people” due to her being AFAB. The other participants mirrored these frustrations, noting that stereotypical understandings of ADHD were problematic in their interpersonal relationships. Even when loved ones recognised that their ADHD is indeed impairing, the participants noted other barriers to feeling understood:

> … my dad, who, who has ADHD, like he, he has issues, he knows how it is. His issues are different, so he doesn’t understand me, like, perfectly. But he knows how it feels to have … *a* problem. So, he was … both, like, more open and less open because he was like, “I know you have a problem, but I know what that problem is” … (Charlie, 19)

Like Charlie, most of the participants with parents who were formally diagnosed with ADHD explained that the differences in their traits sometimes led to invalidation. Charlie explained working optimally by multitasking, whereas her father primarily “hyper-focuses” on one thing. She thus expressed feeling “micromanaged” by her parents growing up. This is because she felt they misunderstand her unique methods of doing schoolwork, which often led to them attempting to enforce different work strategies on her.

For some participants, despite no formal diagnosis, they noticed obvious signs of undiagnosed neurodivergence in their family members. For these participants, similar barriers occurred to feeling understood:

> I didn't talk, as a kid, so everyone saw it as, uh, good behaviour, when, it wasn't, really, good behaviour, it's just, I was, scared. And, with, um, always working hard. … I would always stay up late, to do my work, so then, it would be like, "Oh, the smart family member", when, in reality, I just, found it, uh, very difficult, to work, during the day. … I just don't like, when my place is messy, or unorganized, so, I'm always working at home, to like, clean the place. So, with my family members, uh, they are, African, so, it's seen as a, good trait, when, I'm just getting, like, annoyed by, how messy, or cluttered things are. (Anele, 18)

Above Anele explained that her ADHD diagnosis allowed her to understand herself better. She said her neurodivergence, for one, made her unable to work during the day while her family members were loud. She further explained feeling like her social anxiety, due to being bullied for her ADHD traits, is what led to her being reserved as a child. Although many of her ADHD traits are celebrated by her family, and her undiagnosed family members share similar ones, she explained being unable to tell them of her diagnosis. This is due to their limited understanding of mental health, which she felt would complicate her relationships with them. Thus, despite being celebrated for "good behaviour", Anele expressed still feeling slightly unseen.

1.3 Rejection sensitivity. This sub-theme depicts the multiple ways most participants revealed being sensitive to rejection and seeing this sensitivity as a hinderance to experiencing fulfilling relationships. They all found their efforts to avoid rejection as troublesome, saying that it sometimes led them to feel cautious with and around others. For one, some participants explained that their rejection sensitivity resulted in them struggling to express their opinions:

> … I'm … trying to, not as much, but like, definitely, like, when I was younger, I would like, also, like, soften my opinions, or like, what I was saying, to like, not like, offend, or like, risk that, like, rejection, kind of thing. … just, like, find, like, a middle ground … (Amy, 22)

> I think the fear of rejection, made me … scared to lose friends. So, I would never, like, say no to them, or, you know, put my own needs first, or even express my own worries, or something, because I had that fear … (Lena, 20)

As noted by Amy, her aversion to rejection meant that she would try raise opinions in a manner that was diplomatic and amicable. She explained this to be in an effort to avoid conflict and remain liked by others. As seen in Lena's account, her sensitivity to rejection meant that she avoided raising thoughts that contradicted those of her friends. Many participants noted similar reasons for their current or historic struggles in asserting boundaries and speaking freely with loved ones.

At times, the participants also explained perceiving their rejection sensitivity as hindering their ability to make friends at all:

> I - I don't usually want to talk to people … I'm always, like, afraid of, uh, being rejected, so then, I guess, I reject myself first. Even when, like, people, um, do try to talk to me, I always, like, push them away, because, I guess, I don't want them to see me, and then think, that, they don't like me, anymore, because of the way I am, as a person. (Anele, 18)

> … sometimes when I get hyper, they would get annoyed with me. … which kind of … led me, to like, permanently withdrawing, uhm, because I just felt like I was too much for everyone. … I would just read books by myself. … And … there were attempts, by, like, the teachers, they're like, "Oh no, this kid is isolating themselves … ask a friend to go invite them to play!", and then I would just say, "No" … (Jemma, 21)

The participants mentioned experiencing countless instances of unintentionally annoying others due to their ADHD traits. As such, some explained that they choose to "push" people away or "withdraw" altogether to try avoiding future rejection. Some participants explained that their rejection sensitivity resulted in them completely hiding certain aspects of their lives, interests, or personalities:

> But I get so stressed throwing parties, especially if it involves, like, bringing together friends from different sections of my life. Like, I would rather not do that, like … nothing terrifies me more than, like, introducing people I have met in different situations. I [worry that], "These people aren't gonna like each other, and then they're gonna take it, like, why does *Clare* like that person?" (Clare, 23)
>
> … I kind of end up, um, trying to conform, to conform to the way they are. So, then talking about the things they want to talk about, um, kind of fitting into the mould that they are in. And I have noticed how it differs from, like, friend group to friend group. (Nadia, 22)

As depicted by Clare and Nadia, they feel they behave quite differently around different friend groups. As such, Clare expressed worrying that the contrast between her different social groups might potentially lead some of them to seeing her differently and rejecting her. This thus means that she solely meets different friend groups in specific contexts. Similarly for Nadia, despite not feeling free to discuss her interests with her friends, she explained that this was better for her than potentially losing friends due to their interests not aligning.

Many of the participants also mentioned that their own rejection sensitivity meant that they were careful not to hurt other peoples' feelings. For example, Palesa reflected on why she believes she is often indecisive with romantic interests:

> I don't like hurting others. I know what it feels like to be rejected, and I would hate to be the reason someone else feels that way. I also wouldn't want for the person to end up resenting me for not reciprocating their feelings, or to feel like I wasted their time. I think this is partially due to me having people pleasing tendencies. With this in mind, I guess

> I’m afraid to reject them because them distancing themselves from me, so they can get over me, would make me feel rejected. (Palesa, 23)

Like Palesa, many of the other participants explained struggling with potentially hurting others’ feelings. They explained that the repercussions of doing so might also lead to their own rejection. As such, the participants indicated often “people pleasing” to avoid such encounters.

1.4 Navigating neurotypical norms. The participants described neurotypical social expectations as often complicating their interpersonal relations. Neurotypical norms were explained to influence the ways participants interacted with others by being used to avoid potentially negative experiences. However, the participants conveyed that navigating neurotypical norms ultimately jeopardised their relationships in some ways.

As previously referenced, the participants felt aware of how their talkativeness might impact others. They explained compensating by consciously letting others speak more. However, some participants worried that such conversations lacked reciprocity, thus making them feel unheard:

> I have an older sister … and actually with one of my housemates, as well, I have this difficulty, that, both of them are people, that, like, will kind of talk *at* you, and monologue … and not really, ask so much back. … I get, really, frustrated in those situations … because, I can only pay attention for so long, and then … I don't really know what *I* wanna talk about. And, I'm not gonna bring it up, because … I am kind of like that in general. … I won’t, like, you know … vent to somebody very often. (Anika, 31)

For Anika, she explained that when people “monologue” she starts to feel disengaged, thus losing concentration. Although she recognises that she naturally struggles to “vent”, she explained feeling further unable to discuss her own topics in conversations where loved ones do not directly invite disclosure. As such, Anika found such relationships difficult to navigate. Many of the participants conveyed similar feelings, explicating that they sometimes resented loved ones who did not reciprocate their efforts to be agreeable as according to neurotypical social norms.

Similarly to Anika, the other participants expressed often losing concentration in conversations. They however noted hiding this from loved ones when it happened:

> … like, especially like, when having conversions, and I would, like, lose focus, and come back, and then, like, try and piece together what the conflict was about. Like, it was never, just the, … "Listen, this is what happened". … because I think, um, it, it, it also just comes across as just, being, like, inconsiderate. (Priya, 21)

Priya and all the other participants explained that their ADHD traits were often misconstrued, despite loved ones knowing of their diagnosis. Being used to 'piecing together' conversations, Priya and the other participants reported that they will often do this instead of risking seeming "inconsiderate" after admitting they lost focus. However, the participants also reported feeling unconsidered when their ADHD-related impairments are taken personally by loved ones. Nonetheless, the participants agreed that their masking efforts during conversations could be harmful for relationships as they might miss important information.

The participants all distinguished conversations as especially important interactions in which to adhere to neurotypical standards to avoid upsetting loved ones. However, this was reported to often require considerable effort:

> I ever have to talk to someone, about, some-thing, that's kind of, like, important, or if there's, like, any … conflict, or anything … I'll talk it through in my head, and I'll, like, think about the different ways they could, like, respond. I'll literally, like, you know, stay awake for like hours, like, in my bed. … 'Cause … when I'm … anxious, or stressed, in a conversation, my, like, mind, just, like, goes, completely blank … so, I wanna, like, prepare, as much as I can … so that I don't have to say, like, "Oh, sorry, like, my mind's gone blank" … (Amy, 22)

Like Amy, many of the participants expressed feeling anxious in anticipation of impending conversations. This was often compounded by these conversations being serious in nature, such as when they involved conflict or boundary-setting. Some participants explained trying to avoid such conversations altogether due to how much energy they required from them.

However, if and when unavoidable, many of the participants explained that they would sometimes script these, and even more routine conversations with others. However, the participants also explained that they worry about the sustainability of working that hard to meet neurotypical norms:

> I struggled a lot with, like, seeing other people interact and being, like, “I need to do that to be successful”. But then if I do that, it’s very, like, disingenuous for me because I’m like, “This isn’t going to get me anywhere permanent because it’s not, like, real or true or, like, how I’m actually, like, behave and react and things”. So, like, I struggled a lot to, like … try and find a balance, and I still, haven’t really found … a balance between being … disingenuous and, like, functioning. (Charlie, 19)

Above, Charlie communicated the same conflicting cognitions mentioned by many of the participants. The participants reported recognizing the utility of adapting to neurotypical norms. Nevertheless, they worried about whether they were presenting a façade that made them seem different than who they felt they really were. They thus worried whether failing to maintain this façade could compromise their relationships over time.

Some participants also experienced cognitive dissonance if they sometimes got upset at neurodivergent loved ones who struggled to adhere to neurotypical social norms. For one, Amy revealed feeling “self-righteous” due to her tension with an ADHD-diagnosed friend who often interrupts her in conversations:

> … “Hey man, like, I also … find this really, really hard, but like, please, like, don't”, like, and I think, also, it was because, I'm [*sic*] like … try so hard, to *not* do that. It like … almost, like, meant more, that she *did* do it, because it was, like, something that I'm so restrictive, with myself, and have, like, no compassion, with myself, for, that then, I, like, didn't for her either. … it was really frustrating, because … “I'm … trying to have a conversation with you, and you're … the only one talking” … (Amy, 22)

Amy explained that due to her being “restrictive” with herself in navigating conversations according to neurotypical standards, she found it “frustrating” that her ADHD-diagnosed friend did not offer her the same courtesy. As such, the participants felt hypocritical if they got upset at loved ones for not adhering to these norms. Consequently, they reported wanting to be more understanding of both loved ones and themselves so that traits typical of ADHD do not lead to tension. Notably, getting upset at others' ADHD-traits was only noted in a few participants, of which all were relatively newly diagnosed with the condition.

Similarly, many participants relayed feeling RSD in response to loved ones not responding to their messages. However, the participants reported similar struggles with maintaining virtual contact. A few explained that, at times, being overwhelmed results in not checking their phones. Others explained that sometimes they purposefully neglect their phones to avoid distractions from everyday tasks. Others, like Anika, described that after moving away, there can be a tendency to forget about people, and thus not keep touch:

> … I only really have, like, a few close friends … there are some that I will forget about momentarily. … I didn't know that that was a big, ADHD thing, like, 'out of sight, out of mind'. … So, now that I've been in Cape Town for a long time … it was kind of, the longest-term friendships that I've had … for that reason, I guess … I just, hold onto them for dear life. (Anika, 31)

Nonetheless, the participants expressed feeling troubled by their history of drifting from people due to difficulties maintaining contact. The participants thus compensated by 'holding onto' people they see regularly. This is because these face-to-face interactions allowed these relationships to flourish despite limited online communication. As a result, the participants rationalised keeping even friends who even fell short of supporting or accepting them, to avoid loneliness.

2. Strategising to find connection

As depicted in the first theme, the participants described several barriers that deterred them from having close connections with others. The participants often explained that there were inherent difficulties involved with functioning differently to others. As such, the participants explained often consciously strategising to find and build connection with others. These strategies involve monitoring themselves, seeking validation from others, disclosing their ADHD diagnosis, and finding similar people to connect with. The participants described these efforts as being attempts to meet both their own interpersonal needs, and those of others. This theme depicts the different ways the participants negotiated interpersonal relationships as per these strategies.

2.1 Self-monitoring and compensation. As portrayed in previous sub-themes, the participants often felt their ADHD traits caused misunderstandings, thus compromising their relationships. The participants thus explained monitored themselves to try preventing unnecessary complications in growing closer to others. Often, the participants rendered this self-monitoring as a means to compensate for their perceived (either self-identified or as thought by others) shortcomings. For one, Charlie reflected on camouflaging her ADHD traits after realizing they are deemed "annoying":

> … a lot of people didn't like me. … I wasn't, like, very aware of how to mitigate … having [a] two-way conversation. … I really didn't understand [that] any of these behaviours were, as, like, an, um, ADHD thing. … I was just like, "People don't like me because I'm unlikable" … not, like, … "People don't like me because of these traits". … But then when I got, like, in my teens, I was like, "… I talk too much. … People find pen flicking annoying …" … what I [needed] to do … [was] sort of, like, identified over time, and … performed. (Charlie, 19)

Although taxing to monitor oneself, the participants, like Charlie, explained that it afforded them easier relationships. For one, "pen flicking", amongst others, were "stims" that some participants felt willing to limit in order to avoid unnecessary difficulties with others. Similarly, the participants explained that being mindful of what they said was also helpful to avoid jeopardizing relationships with peers:

> I've always kind of felt, like, I don't always relate … I don't want to put my foot in my mouth and, like, say something very weird. … If I just don't have something to say, I won't say anything. … And, I mean, like, small talk just doesn't work for me sometimes. So, then I'll be quiet and then it's kind of … at least, like, I'm not messing up that conversation. (Clare, 23)

For Clare, people’s reactions to the things she said made her learn early on that the easiest social survival method was to monitor herself. Since Clare was uncomfortable with things like small talk, she would try and connect in ways that felt more natural to her. However, this resulted in her saying things that she eventually learnt were considered “weird”. To prevent this, Clare decided it was easiest to be quiet.

Another motivation to self-monitor, as explained by the participants, was due to their consideration of others:

> … I'm kind of, untidy. But not, to, like, a dirty, level, but, I'm untidy, like, I leave stuff, around, mostly so that I can see it, and remember it. And so, like, I felt the need, to like, constantly, like, clean. (Lena, 20)
>
> I think, um, like, a problem that emerged, was that, like, my attention span would sometimes be short, and I get, like, excited over, like, different things … my friends sometimes don't feel heard. Um, or I'd try and find, like, solutions for all their problems, instead of just, like, being a good friend and listening. (Priya, 21)

As detailed by Lena, her being “untidy” was functionally motivated, as she mentioned struggling with “object permanence”. However, after getting a roommate, Lena compensated for this by “constantly” cleaning. With Priya, she revealed feeling responsible for derailing conversations when her friends try open up. She explained that due to her friends’ also being neurodivergent, they “hop on the bandwagon” and eventually end up forgetting the initial topic. Despite the temporary mutual excitement felt by both parties, Priya empathises that her friends, over time, might feel “unheard”. She similarly is aware that offering “solutions” might not be what loved ones need or expect after raising concerns. Thus, Priya, like the other participants, noted trying to work on their listening skills to facilitate their relationships.

The participants also described being cautious of how they assess others’ motives, feelings, and behaviours:

> … it's very hard for me to feel, like, rejected. Even if I'm not outwardly being rejected, but, like, “Oh my gosh, they’re not answering my message - maybe they suddenly hate me!” … I'm not very good at reading people’s, like, um, demeanour, and how … they

> are. … also, like, [with] the heightened rejection sensitivity … my mind just always goes straight to the negative, instead of maybe the positive things … (Lena, 20)
>
> So, I don't know if that's because, just because of, like, a lack of emotional attunement in my childhood, or if it's a symptom of ADHD. … But I think for a long time I struggled to feel my emotions and to identify other people's emotions, or empathise with them, in like, a, on a deeper level, instead of just being, like, "Oh, that's a sad thing to go through". (Palesa, 23)

Palesa and Lena, like a few other participants, explained feeling like they may not always "read" others accurately or recognize others' emotions instinctively. Due to this, they explained trying to rationalise in case their initial assumptions are incorrect. This was perceived by them to avoid instigating misunderstandings in relationships.

Similarly, some participants expressed monitoring themselves by being weary of their excitement in new relationships:

> … I am very prone to developing intense crushes very quickly. I become very enamoured and will set people on a pedestal … I think it may be because of how excited they make me feel. … It then becomes difficult because I start to overthink everything. … I think I enjoy these things as an idea … (Nadia, 22)

Like Nadia, some participants expressed trying to avoid failed relationships by evaluating their "crushes", for one. Due to some participants feeling like they can sometimes "lose perspective" by viewing others on a "pedestal", they explained taking time to evaluate whether they are not at risk of "impulsively" entering new relationships. Sometimes, as with Nadia, this was described to make the participants "overthink". Nevertheless, this was one of several ways that the participants expressed strategising to begin and/or maintain only meaningful or fruitful relationships.

2.2 Seeking validation in achievement and likability. The participants expressed that they enjoyed and held onto instances where loved ones complimented them. They thus mentioned often working hard to maximise being validated by others. Some things that they clarified getting validation from are their achievements, humour, or personalities overall. These harmonious interactions, from being validated, were experienced as a nice contrast to being misunderstood for their neurodivergence.

To start, growing up having been so often criticised, many participants deciphered that they started craving praise:

> … my parents are the type to find the wrong before they find their right. … and my mother was the biggest advocate for that. So, she would come home, and she'd be like, "But this is not in place and this and this and this and this", instead of saying, "Thank you. You did such a good job. Well done". So, a lot of my life, I have been reprimanded instead of rewarded. … So, because of all of that … I would do my best to try and get that reward. … just, like, that, "Well done" … (Toni, 24)

All the participants noted having above average academic capabilities, and all also explained that they were socially rewarded for their academic achievements. As such, the participants learnt from an early age that their external achievements, such as their academic performance, would grant them social capital:

> I always enjoyed … school, and like, got validation from it, because, I was, like, doing well, and like, people pleasing. And so, it was, like, quite a, like, a rewarding, endeavour … even if I was, like, bored in certain classes, I, like, kind of just got away with, not really paying attention, or … sleeping through them … (Amy, 22)

> I'd forget that stuff was due … I guess I was lucky in the sense that the teachers knew I did well. So, they weren't, like, they didn't think I was, like, trying to get out of work, or something like that. (Tanya, 19)

As seen above, Tanya and Amy's high marks in high school made teachers more lenient with them. While not all the participants were rewarded with lenience for their grades, all explained that it provided them with some sort of reward, even from friends or peers:

> We had a math test … and I got 100%. And the teacher announced it to the class, and everyone came, came up to me afterwards, and they're like, "Oh my gosh. You got 100%!". And then after that I really noticed a change in people's behaviour towards me. (Palesa, 23)

> … I came first. And this was, like, a complete surprise to me, because I never, like, put in effort … to become, like, first. … And then … people started being way nicer to me and wanting to be my friend! It was so weird. … But … then I liked … how that made me feel. (Nadia, 22)

As noted above, Palesa and Nadia were treated better by their classmates and peers after their academic achievements became public knowledge. As such, many of the participants expressed seeking out validation via performing well academically. They however expound that this academic validation became harder to maintain as most started experiencing greater academic challenges in tertiary schooling. Thus, many participants confessed even sacrificing their health to maintain their "perfectionistic" standards.

Similarly, the participants said they were sometimes admired by peers for getting work done under intense time constraints:

> … like, if it's crunch time, and, like, just being able to crunch everything into one. And, like, I'm telling the story to my friends, and it's, like, comic gold. And it's like, "Okay", like, "I'm not really receiving negative feedback". (Palesa, 23)

Palesa explained that the anxiety of an impending deadline counters her executive dysfunction and allows her to hyper-focus on her work. This results in her getting things done in a fraction of the time than would be reasonably expected. When discussing these experiences with friends, not only are they in awe of her miraculous achievements, but they also find her stories humorous. However, Palesa's friends focus on the 'comic gold' and are distracted from recognising the underlying difficulties that Palesa faces to continuously be in situations that require "crunch[ing] everything into one". While Palesa appreciates entertaining her friends, she also reasoned that making light of her struggles protects her from being perceived as incompetent. Like Palesa, Anika tries to present as somewhat nonchalant in relation to her academic difficulties:

> … the people in our office … know that I will generally … kind of hide out … and don't want to talk about work … and if I do, I'll probably make some kind of, like, dismissive statement. … what is the word – like, self-deprecating, kind of remarks, is something that I've also just started doing, without even realizing. … it's kind of become, this kind of, defence thing. (Anika, 31)

In Anika's case, she also conceals the underlying vulnerability related to her academic struggles. She explained utilising two main "defence" strategies, namely avoiding conversation and people altogether, or using humour via her "self-deprecating" remarks. Like Palesa and Anika, many participants mentioned being unable to completely conceal their academic struggles. Instead, they expressed trying to control the narrative through humour. Anika and Palesa still explained deriving benefit from compensating for their perceived shortcomings by at least being "good company" instead of 'burdening' others with their stress.

Likewise, most participants said being liked was a source of validation. Tanya explained: "I can adjust my personality to a specific type of person so they would like me". Many echoed this, mentioning that they were able to "gauge quite early on" (Nadia, 22) how they could be liked by different groups of people. As such, some participants explained using their "bubbly", "funny", and "creative" nature, which was seen to be due to their ADHD, to be liked.

Similarly, Priya reflected on being the one to disguise the "tense" atmosphere in her household by "being the life of the house". She explained that her hyperactivity made her talkative, and that she thus felt obliged to liven up the mood. More so, she said it was expected of her to maintain this role by her family. Priya, however, noticed feeling conflicted: "I would feel disconnected from myself … if I didn't have that energy". She further described finding it "subconsciously draining", as it became a conscious effort to remain 'energetic' even if her internal mood did not correlate with this.

Most participants also noted that their ability to mask resulted in them seeming less impaired, but to their detriment. Amy commented the following about her attempts to seek support from friends before aware of her ADHD:

> … I would, like, talk to friends … and they would be like, “What are you complaining about? Like, you're doing well, you're getting better marks than me”. … you end up, like … not feeling like you have much support … (Amy, 22)

While Amy knows she deserved more empathy and support, she also blamed herself for “people pleasing” and seeking “validation” via her academics. She reported feeling like this prevented her from being diagnosed with ADHD earlier: “… another thing that, like, stopped me from being diagnosed … was, I … would do what it took, to like, get approval. … [I] definitely … downplayed my symptoms”.

2.3 Disclosing ADHD diagnosis. All the participants explained that their ADHD was an integral and inherent part of who they are: “I don’t see it as something that’s, like, I don’t see it as … a disorder. Like, obviously it makes you different but, like, for me, it’s, like, who I am” (Tanya, 19). As such, they expound that hiding their ADHD diagnosis from others creates an invisible divide that stops them from feeling understood or seen. It is for this reason that they felt informing others of their ADHD diagnosis could help foster closer or more open relationships. However, due to others potentially stigmatising or misunderstanding them, many participants expressed carefully considering when or if disclosure would be beneficial.

The participants explained being cognisant of some of their loved ones’ misconceptions about ADHD. Anele, who had only been diagnosed with ADHD for about two months at the time of the interview, strongly expressed not wanting to tell loved ones from her hometown about her diagnosis. She believed this prevented complications such as having people treat her differently, similar to the unwanted consequences of disclosing her depression to friends when she was in high school:

> I prefer not to, um, tell people at all. Because, when I did get my, um, diagnosis for, like, depression, if I would tell people, then I notice they start treating me differently, or – they wouldn't say they don't want to be my friend anymore, but they would not hang out with me [as] often. … they would stop doing certain things because they [thought] that it would, like, upset me. So … I don't…want [people] to change how they treat me … (Anele, 18)

Anele reported not wanting people to perhaps pity her and compensate by being overly kind and affectionate. She explained that friends became less playful with her after discovery of her depression, as they perhaps began to see her as fragile. As such, Anele explained feeling distant from her friends, rather than feeling closer to them after sharing something so vulnerable. The long-term consequence of being profiled, for her, over-shadowed the momentary relief of being open with loved ones. Moreover, she explained that predominant stereotypes associated with mental health in her community could possibly lead to loved ones seeing her less objectively. It was thus reported to help prevent this by hiding her diagnosis.

While Anele felt that those who knew her well may see her differently after knowledge of her ADHD, many of the other participants instead mentioned that they needed to first build a reputation before disclosure. For example, Amy said the following: “I'd want them to know more about who I am before I tell them, so they don’t, like, put me, in a box”. Similarly, Jemma explained that she is hesitant about sharing her diagnosis with people she is still getting to know, and prefers to gauge whether disclosure is necessary:

> … if I'm the one to bring it up first, it's only in situations where, like, I need, I feel like I need to explain something. … I need to explain, like, “Oh, I have ADHD, and this is why I do this”. (Jemma, 21)

As seen above, Jemma will at times let even strangers know of her ADHD as a sort of ‘disclaimer’ to shield her from misjudgement. Charlie similarly explained that she “always” tells peers of her ADHD, so that they can be more understanding of her: “I just want them to know that if I’m doing something, it’s probably not bad on purpose”. Clare similarly explained that knowledge of her ADHD could improve her social interactions:

> I started telling people … at least in grade 5 … because, like, before that, nobody knows what anything is. … so that would be pointless. But, ja, I’ve always been pretty open about it, especially because. … I feel like you face less harsh criticism, because people are like, “Let me take into account that there is something diagnosed”. (Clare, 23)

As seen in this quote, Clare started informing peers of her ADHD as soon as they could reasonably understand what this meant. While they may not have had adequate knowledge to understand the exact extent to which it explained Clare's differences, knowing that there was a clinical diagnosis slightly buffered potential criticism from others.

Notably, all of the participants agreed that not being considered the stereotypical depiction of someone with ADHD often leads to invalidation. Anika noted: "people just don't understand, they'll just be, like, … "You're doing a PhD … you don't seem that hyper"". Similarly, Jemma illustrated that "the stereotype of someone with ADHD is this little boy in a classroom who's uncontrolled and he's loud, and that's just not how [hers] presents". Nonetheless, most participants resolved that they chose to be public about their ADHD as often as possible, despite the risk of negation and denial from others:

> … the more I learn about it, the more I'm like, "Ja, screw it. I'm just gonna own it, and people must know this about me … and also … mustn't take for granted that their brains function normally." (Anika, 31)
>
> I feel quite … open about it. Because I think, as well, like, if I had met someone that was like me, um, who said, like, "Oh ja, I have ADHD and this is how it shows up", like, I, it, would have helped me to be diagnosed sooner. (Amy, 22)

As in these quotes, several participants mentioned trying to spread awareness due to feeling a social responsibility to advocate for themselves and others like them. They expressed that speaking on the matter was close to their hearts. Amy further mentioned that her raising awareness led to some of her friends subsequently getting diagnosed with ADHD. As such, Amy, Anika, and the other participants revealed being public about their diagnosis even if this risked invalidation or tension in their relationships.

2.4 Finding similar people. The participants described that relationships with similar people were often naturally easier to develop and maintain. At times the participants said that similar people are those who are also neurodivergent. Other times they appreciated people who were perceived to be like-minded in different ways, such as by being open-minded or empathic. The participants also noted that they sometimes strategized to maintain friendships based on shared interests. For one, they explained that getting to know someone who displays neurodivergent traits feels safer and easier:

> … I’ve always kind of had friends around me who’ve been similar. … I’ve had lots of issues [with] just, like, infantilisation, and stuff like that. So, I don’t really wanna put myself up, out to that. Um, but I mean, if it’s someone who I’ve [seen] hints of [neurodivergence from], then I will talk to them. (Clare, 23)

As with Clare, the participants rationalised often feeling more comfortable around people who seemed neurodivergent. While not every neurotypical person would infantilise or judge them, the participants expressed feeling like neurotypical-seeming people are more likely to subject them to these experiences. While some of the participants noted that they did not necessarily seek out only neurodivergent friends, they deciphered that connecting with neurodivergent people happened naturally:

> We kind of just find, find each other. … And now in university, I think … less people have ADHD, but there’s also, like, a wider variety … it’s more, like, a neurodivergent group than an ADHD-specific group. … I’m friends with a lot of people who are on, like, the autism spectrum, or who have ADHD, or who have, like, seasonal affective disorder. And honestly, that’s not, like, the same type of thing but, like, they are neurodiverse. (Charlie, 19)

All the participants felt unfulfilled in relationships where they were met with sympathy, at most, and were not truly understood. They thus explained seeking out neurodiverse people who were more likely to empathise with their difficulties. However, growing up, not all the participants had access to people who seemed neurodivergent. In these cases, they found safety in people who were considered ‘outsiders’:

> … as a kid, if everybody's in the middle of the playground, I would go, like, far, like, to where other people don't play. And most of the time, [there will] also be, like, the kids that were considered weird, there. … I guess I felt, more comfortable there, than being around … people that are considered normal. I don't … like, uh, hanging around people

> that … don't have, like, any mental illness, or something that's, weird, about them. I don't feel, uh, accepted there. (Anele, 18)

As seen with Anele, the participants explained that befriending people who seemed to experience any sort of hardship, was easier. This is due to the perception that these people would be better able to understand them via the shared experiences of being or feeling different from general society. Not only this, but these kinds of people also seemed less likely to hold the participants to unpleasant social expectations. The participants ultimately felt these types of people are generally more accepting and open-minded, which would help in forming meaningful relationships.

On the other hand, having ADHD-diagnosed and/or other neurodivergent loved ones was reported to be extremely beneficial for the participants. One benefit was that the participants were able to learn more about their own functioning by seeing how their loved ones' neurodivergence manifested. For example, Palesa noted that her only ADHD-diagnosed friend informed her that some of their similarities were manifestations of their ADHD. Also, Clare noted that she discovered her hyperactive ADHD traits after observing that her boyfriend, who has ADHD-I, "slows down to a crawl" when he forgets to take his medication.

Adjacent to this, the participants were better supported by their neurodivergent loved ones. Clare explained that her boyfriend is "the one who taught [her] how to actually study". Lena also noted that her neurodivergent friends often "shout at [her] to take [her] medication" and see when she is experiencing sensory overload or auditory processing issues that result in her struggling in conversations:

> … I can't, like, follow … a lot of the times when I'm talking to people …and then my friend will be like, uhm, "Hey Lena, this is what this person said". … because they'll often see me, like, looking at somebody, and they ask me a question, and I just don't respond. (Lena, 20)

Lena revealed feeling comforted by being understood by loved ones who shared similar sensory and auditory processing differences. She also appreciates being assisted by her friends without having to explain or defend herself. The participants disclosed being similarly accommodating and understanding of their neurodivergent loved ones:

> … with the people who don't understand, like, … just being hyper, or … not necessarily paying attention to the whole conversation … it has … affected dynamics. … some of my friends also have ADHD, and I'm like, “Don't worry about it, I get it”, like, but then, some people who don't have ADHD, they sometimes get … offended. … like, “Am I boring you?”. (Jemma, 21)

As she described, Jemma was able to support her friends with ADHD by being understanding if they lost focus during conversations. Her having similar struggles with attention also means that she finds it less offensive. As such, mutual grace is offered in these kinds of friendships. Similarly, the participants appreciate the non-judgemental attitude that neurodivergent loved ones have towards their unique methods of social engagement:

> When I’m with my friends, I can fall asleep and it’s fine because we all neurotypical [*sic*] in some way or another – we understand when we do certain things. And if we don’t understand, we can explain it to each other and then we understand. (Toni, 24)

Toni described that having a neurodivergent friend group meant that they were mutually comfortable around each other to spend time together in supposedly unconventional ways. Like Toni, many participants felt freer to ask for unique support and company from neurodivergent loved ones. They also illustrated being similarly willing to return the same unconventional support and company to others.

Lastly, the participants expressed finding it relieving to have light-hearted interactions with loved ones about their neurodivergent traits:

> I always joke with my roommates that when it’s my week to clean the house I take the Ritalin, ‘cause it’s the only way, like, I actually get myself to start cleaning. … my roommate also has ADHD, so we always send each other, like, TikToks … being like, “Haha, this is funny! This is literally us!” … (Tanya, 19)

> Like … my gran … did a lot of, “Oh, she’s just doing a Clare”. … I appreciate it because it’s just, like, actually, like, it’s being seen … it’s just who you are … it was never really said maliciously. (Clare, 23)

As mentioned by Clare and Tanya, it is comforting or enjoyable to also joke about their neurodivergence with people who get it. For Clare, who notes that most of her family are neurodivergent, her grandmother laughing off her mishaps makes her feel “seen”. The ability to openly discuss, and even poke fun at their neurodivergence, was an important aspect of having holistic and comfortable relations with loved ones for the participants. These relationships are the most fulfilling.

Summary of Chapter

This chapter detailed the participants’ experiences of relationships. In the following and final chapter, the implications of these findings will be discussed, and my conclusions presented.

CHAPTER 5: DISCUSSION AND CONCLUSION

Research has shown that individuals with ADHD often experience social and interpersonal difficulties. Adults with the condition regularly incur mental health challenges, and AFAB university students are a particularly vulnerable demographic that remains under-researched. Consequently, this study aimed to explore AFAB university students' lived experiences of their interpersonal relationships. In this concluding chapter I will discuss and summarise my findings. This will entail my interpretation of the data, as guided by previous literature, and it will also highlight how my findings compare and contrast with what similar studies have found. I will conclude the chapter by outlining the study's strengths and limitations and make recommendations concerning directions for future research.

Summary of Findings

My findings consisted of two overarching themes that were each divided into four sub-themes. From these two main themes, '*compromised connection and vulnerability*' and '*strategizing to find connection*', the participants seemed to indicate that having ADHD often directly and indirectly interferes with their interpersonal relationships. The first theme identified that the participants experienced several barriers to feeling close to or more able to be vulnerable with others. My second theme determined that the participants often had to strategize to counter these barriers, and thus counter feeling unsupported, lonely, or dissatisfied in their relationships. Several of my findings intuitively align with previous research. Nonetheless, to the best of my knowledge, this study is the first to address this topic in the South African context, and exclusively regarding the experiences of AFAB university students. In light of this, novel findings were noted that potentially highlight how these unique factors inform the relational experiences of adults with ADHD.

Compromised connection and vulnerability

In the first theme, circumstances thought to compromise the participants' relationships were often related to their ADHD traits being judged or misunderstood by others, aligning with findings from existing literature (e.g., Attoe & Climie, 2023; Ginapp et al., 2023a; Kwon et al., 2018; Wymbs et al., 2021). Participants in this study used words such as lazy, impulsive, flaky, overly talkative, unmotivated (scholastically and generally), and weird (e.g., for saying 'inappropriate' things) to describe their sense of how others perceive them. These findings were expected as studies have found that ADHD symptoms are often societally deemed incompatible with notions of 'ideal' femininity (Hayashi et al., 2019; Kok et al., 2016; Young et al., 2020). Systematic reviews of studies about ADHD in females have found that girls exhibiting overt symptoms stand out for deviating from what is expected of them and are consequently often rejected and alienated from peers (Attoe & Climie, 2023; Kok et al., 2016).

In the first sub-theme, '*vigilance of others' perceptions*', the alienation that participants identified as a result of others' perceptions was the same as that experienced in childhood for behaving, according to others, out of the norm. In this sub-theme, the participants seemed hyperaware of others' negative and/or inaccurate perceptions about them, which, they explained, often had lasting consequences for how they viewed themselves. For example, one participant noted feeling like the "crazy one" due to others misattributing their ADHD traits to defiance. These results thus highlight one mechanism that might account for previous studies' suggestions that poor interpersonal relations often correlate with poor mental health in girls (Kok et al., 2016), as worrying self-thoughts were demonstrated to develop in response to retrospective social isolation. This study also extends previous research by showing that, despite their gender identities, the social experiences and self-concepts of gender-diverse participants (42% of my sample) were similarly implicated by their ADHD symptoms being deemed unpalatable by others.

In addition to sometimes negatively impacting their self-esteem, these findings suggest that prior social experiences often prompted the participants to feel guarded with others and tailor their behaviour accordingly, corroborating previous research which also found ADHD populations to feel guarded socially (Attoe & Climie, 2023; Ginapp et al., 2023b; Kwon et al., 2018; McKeague et al., 2015). Within the '*vigilance of others' perceptions*' subtheme, this tailored behaviour took the form of being cognisant to not 'take over' or interrupt conversations and trying to be self-reliant to avoid "burdening" others with one's 'extreme' emotions and complex needs. In the sub-theme identified as '*feeling judged and misunderstood*', this tailoring of the self was seen in limiting advice seeking and selectively rebutting loved ones' invalidation of their mental functioning. In the sub-theme '*rejection sensitivity*', this was struggling to voice opinions and set boundaries; self-isolating and pushing people away; conforming to others' interests while failing to divulge one's own; and avoiding hosting social gatherings. In '*navigating neurotypical norms*', the participants limited their talkativeness; scripted impending conversations; masked their inattention in conversations; felt conflicted about whether their displeasure of others' ADHD-like traits was warranted; and strove to maintain even unfulfilling relationships.

While often intended to mitigate negative outcomes, these behaviours potentially compromised the participants' well-being. For one, some participants noted avoiding cancelling/rescheduling plans by straining themselves to meet academic deadlines. Whilst ostensibly out of consideration for others, the participants' access to social support was likely consequently compromised. For instance, informing a loved one of an impending/overdue deadline might solicit receiving comfort and encouragement. However, the participants' apprehension about upsetting or inconveniencing others often led to them struggling in silence. Moreover, these behaviours were ultimately described as hindering the participants' ability to feel open, free, and comfortable with loved ones.

Similarly, in '*navigating neurotypical norms'*, the participants relayed that their efforts to adhere to neurotypical social norms were harmful to their emotional and psychological health. For one, they expressed that monitoring their talkativeness led to resenting loved ones who were not cognisant of the imbalance in these conversations, and the participants ultimately found it difficult to communicate reciprocally. Similarly, avoiding seeming rude by admitting to their inattention in conversations means the participants potentially miss important information from loved ones. Again, however, they felt unable to retrieve this information by unmasking their inattention. As such, this sub-theme seems to highlight both the immense effort underlying camouflaging, and the anxiety-provoking nature of constantly doing so, as similarly found by another study on adults with ADHD (Mylett, 2022). For example, one participant divulged staying up all night to script impending conversations. It is not clear whether this inability to sleep indicated rumination or debilitating anxiety, nonetheless, compromised sleep alone raises the potential for impeded well-being, thus demonstrating the likely negative impact of social camouflaging on the health of the participants.

Whilst several studies show that adults with ADHD often feel invalidated, criticised, and misunderstood (Attoe & Climie, 2023; Beaton et al., 2022; Ginapp et al., 2023a), to my knowledge, this study is the first to note the above listed behaviours as concomitant to these interpersonal experiences. I propose that this is due to limited existing qualitative research exclusively examining ADHD-adults' relationships, as the studies that I have discovered had broader scopes of inquiry. As such, my study extends existing findings by noting these behaviours as specific ways that AFAB ADHD-diagnosed adults might function socially due to their unique interpersonal experiences. These experiences, for participants in my study, align with previous research that has shown individuals with ADHD to be considered ‘too much’ by others, to feel outcasted, and to experience interpersonal conflict over logistic difficulties associated with their ADHD (Attoe & Climie, 2023; Canela et al., 2017; Ginapp et al., 2023a; Hinshaw et al., 2022).

Nonetheless, clinicians with considerable experience in adult-ADHD have noted similar social behaviours in adults with the condition. Articles authored by some practitioners noted that diagnosed adults can often people-please and self-isolate, supposedly due to their RSD (Dodson, 2023; Littman, 2023). Indeed, several participants in my study used the term “people-pleasing” to describe their behaviour. The participants also largely attributed their difficulties with asserting boundaries to rejection sensitivity, aversion to conflict and upsetting others, and trying to protect their relationships. Limited research exists on rejection sensitivity and ADHD. However, studies have investigated its links to depressive symptoms, interpretation bias, and attention to other’s facial expressions, among its potential interpersonal manifestations (e.g., Kraines et al., 2018; Normansell & Wisco, 2017). As most participants in my study indicated a depression diagnosis in their lifetime, their rejection sensitivity might be partially accounted for by their depressive symptoms. Also plausible is that their rejection sensitivity accompanies the social anxiety that some experience. Notwithstanding, neurological studies show that ADHD-diagnosed children display increased sensitivity to peer feedback (Babinski et al., 2019). Although it is not clear whether due to physiology, comorbidities, or environmental factors, my study corroborates existing assertions that ADHD-diagnosed individuals likely experience heightened rejection sensitivity (Beaton et al., 2022; Bondü & Esser, 2015; Dodson, 2020, 2023; Ginapp et al., 2023a, b; Littman, 2023; Swick-Jemison, 2023).

Also corroborating previous research, some participants mentioned sometimes struggling to identify, understand, and voice their emotions (Bora & Pantelis, 2016; Edel et al., 2015; Ginapp et al., 2023b; Kwon et al., 2018; Welkie et al., 2021). In their review of studies, Attoe and Climie (2023) assert that late-diagnosed women with ADHD “have difficulty expressing and or verbalizing their individual needs” (p. 651). In addition to possible alexithymia and/or comorbidities, my findings suggest that one reason the participants felt less willing to voice their emotions was due to worrying that they were “burdening” others. Articles by clinicians similarly explain that women with ADHD often feel societally “[obligated] to accommodate others’ needs” (Littman, 2023, para. 5). My study is thus potentially the first to validate this empirically.

Swick-Jemison (2023), diagnosed with ADHD at 42, further reflected in her autoethnographic study on how common depictions of ADHD negate the prosocial characteristics and intentions observed by many individuals like herself. She reflected on how “ADHD is commonly associated with socially disruptive behaviour” (p. 4) and “anti-social tendencies”, noting a “dichotomy” between this and the “social justice mindset” (p. 5) that research has found to be prominent in ADHD communities (Caldwell, 2022, as sited in Swick-Jemison, 2023). This dichotomy was evident in my study due to the contrast between the participants’ apparent conscientiousness, and the harsh ways their ADHD traits were often responded to by loved ones and society at large. As Swick-Jemison (2023) highlights, that ADHD populations often compensate to prove that they are not anti-social, perhaps the participants in my study placed similar onus on themselves to prevent negative interpersonal encounters.

Although, this onus seemed to be unevenly distributed and perhaps perpetuated self-blame, personalisation, and other negative self-views in some participants. Whilst such cognitions are often linked to internalising mental disorders, which are often comorbid in AFABs with ADHD (Attoe & Climie, 2023; Hinshaw et al., 2022; Young et al., 2020), many participants indicated that they no longer had depression or generalized anxiety. Moreover, these comorbid conditions are often depicted as a result of untimely ADHD diagnosis, and their prognosis is understood to improve post-diagnosis. Whilst my sample likely corroborates the latter, my findings also possibly suggest that adults might experience negative self-cognitions as a result of the alienating experience of being both AFAB and neurodivergent in a predominantly neurotypical world. As such, these factors perhaps predisposed the participants to perceiving their emotions as excessive, and prioritising others’ emotions over their own, rather than being explained by comorbid pathology.

Of concern, participants reported often intentionally hiding their difficulties from others, even their families. Principally, this was mentioned in relation to the participants’ families being far away, as most participants had left home to attend tertiary education. As such, the participants described trying to prevent loved ones from worrying about them if these loved ones would presumably feel helpless due to the distance barrier. However, studies have shown that good parental support is positively associated with better mental health in university students, and those with heightened ADHD symptoms were found to have limited access to satisfactory parental support in comparison to controls (Meinzer et al., 2015). South African literature, moreover, states that tertiary students studying far from their families are more vulnerable to psychological distress (Young & Campbell, 2014). Thus, the present study extends these findings by highlighting a mechanism whereby AFAB university students with ADHD, in particular, might have more limited access to familial support, and thus be vulnerable to psychological distress. Living far from loved ones, as explained by some participants, potentially reinforced their existing tendency to manage their difficulties alone.

Strategizing to find connection

While my first theme entailed what the participants described as barriers to their relationships, the second theme discussed what the participants described as facilitating their relationships. In the first sub-theme, '*self-monitoring and compensation*', the participants explained that despite knowing that their behaviours were due to their neurodivergence, such as stimming with pen-flicking, or being 'untidy' to accommodate their object permanence difficulties, they were cognisant of how these traits might annoy others and impact on their relationships. Consequently, they explained limiting public stimming; being mindful of what they said; keeping quiet altogether; working on their listening skills; monitoring their thoughts to compensate for their potential empathy deficits, or distorted cognitions (e.g., due to RSD); and re-evaluating their excitement towards prospective relationships, corroborating Ginapp et al. (2023a) who found adults with ADHD to sometimes enter novel relationships impulsively. In '*seeking validation in achievement and likability*', the participants attributed some of their ambition and perfectionism to strategizing to be perceived positively via means such as high academic attainment. Some also explained downplaying their worries using self-deprecating, humorous, and nonchalant remarks, and feeling pressured to outwardly maintain an energetic, positive, confident, resourceful, and bubbly demeanour. In '*disclosing ADHD diagnosis*', the participants elucidated that feeling seen meant that others know about and understand their ADHD. As such, it was explained that while hiding their diagnosis was sometimes protective from prejudice, stigma, pity, and invalidation, the participants felt most comfortable with individuals who knew of their ADHD. Finally, in '*finding similar people*', the participants expressed connecting better with people who are similarly neurodivergent or have experienced social exclusion and hardship in life.

Existing studies have similarly suggested that adults with ADHD likely connect better with other neurodivergent people (Ginapp et al., 2023a; Wymbs et al., 2021). The present study further underscores that relationships with other kinds of individuals require considerable effort and can often be unfulfilling. For one, the participants expressed appreciating advice received from ADHD-diagnosed loved ones. This seemed to be a relieving contrast to relationships where the participants were wary of being invalidated or judged after opening up about their struggles. Moreover, the frustration described by these repeated experiences was seen to lead to resentment and similar unpleasant emotions. However, my findings note, like Ginapp et al. (2023a), that relationships with fellow neurodivergent people are also susceptible to disagreements, as seen when the participants divulged feeling unheard by their parents who had different ADHD manifestations to theirs. While Ginapp et al. (2023a) noted these disagreements amongst online ADHD communities, the current study depicts that they can even occur in one’s household.

Research on AFABs diagnosed with ADHD in adulthood has shown that receiving a diagnosis offered a relieving explanation for their experiences, thus improving their self-esteem (Attoe & Climie, 2023). In the present study, the participants rationalised their functioning as due to their neurodivergence, as in ample literature where ADHD-diagnosed individuals considered the condition as inherent to their identity (Ginapp et al., 2023b; Hallberg et al., 2010; Mahdi et al., 2017; Mylett, 2022). Nonetheless, despite often being understanding towards themselves, the participants sometimes had harsh self-appraisals that mirrored others’ intolerance. This finding was concerning given that research on AFABs with ADHD suggests that earlier diagnoses can be protective from the development of negative internalised self-perceptions (Hinshaw et al., 2022; Young et al., 2020). In research on autistic adults, those with childhood diagnoses are similarly seen as feeling less pressure to camouflage due to having had more time to form a self-identity around knowledge of their neurodivergence (Cook et al., 2021). While participants in my study similarly explained sometimes trying to protect their well-being via strategizing to camouflage less, they described camouflaging as having pertinent social benefits, like participants in the scarce studies investigating camouflaging in adults with ADHD (Canela et al., 2017; Mylett, 2022). Also congruent with these studies, however, the participants felt conflicted about camouflaging, describing it as disingenuous, exhausting, and unsustainable.

As such, although camouflaging and seeking validation helped the participants avoid the conflict and misunderstanding that characterised several of their relationships, my findings depict that these behaviours also negatively impacted their well-being. Thus, irrespective of their age at diagnosis, the participants' motivation to camouflage was greatly informed by their interpersonal experiences and the perceived repercussions of camouflaging versus not camouflaging.

Strengths and Limitations

Existing literature has determined that AFABs with ADHD are socially vulnerable to heightened rejection and stigma due to outcomes like unplanned pregnancy and increased criminality (Young et al., 2020). The participants in my study however depicted a relatively elite sub-population of the South African demographic as seen by their position as students attending a prestigious South African university. Thus, as indicated by their capacity to compensate for their impediments via their high academic attainments, the experiences of this sub-population may not be generalisable to other ADHD demographics. However, my study demonstrated the participants' distress as often related to the interpersonal pressure they felt to perform well. As such, several of their social experiences might not apply to demographics that do not have similar interpersonal pressures to produce societally celebrated achievements like good grades.

Nonetheless, stigma, prejudice and social exclusion were evidently still experienced by the participants. As such, this study was able to highlight the microaggressions and other, perhaps more subtle, demonstrations of alienation that can often be experienced by AFAB adults with ADHD in the South African context. Whilst potentially adjacent to their social impairment is the propensity to be overly accommodating and forgiving, my findings should be interpreted in light of the national context. For one, although some participants indicated coming to terms with their families' invalidation of their mental health, several perhaps contextualised their families' views in relation to the notorious and historically oppressive nature of the field of psychology in the country. As such, since mental health inequalities and the legacy of Apartheid perpetuate (Kleintjes & Schneider, 2023; Meyer et al., 2019), the participants' acceptance of their families' often hurtful perspectives might be explainable by their socio-political awareness.

Moreover, whilst from socio-economically diverse backgrounds, in their tertiary environment, all participants had reasonable access to psychiatric care, which does not reflect the broader accessibility of these services to the general South African population. As indicated by their eventual diagnoses, the participants accessed psychological services. As such, their relatively high level of introspection and insight, as seen in my findings, is potentially partially attributable to their prior/recurrent treatments.

Previous researchers have opted to purposefully exclude individuals with comorbidities from ADHD research, as some consider these confounding. Given that most adults with ADHD have comorbidities (Choi et al., 2022), I chose not to exclude this population. As such, my findings likely reflect a multitude of nuanced and complex experiences encompassed within the ADHD community, making them applicable to a wider demographic of AFAB adults with the condition. In any case, yielding generalisable results was beyond the scope of this study.

Lastly, I was reminded during data collection of the potentially ableist configuration of semi-structured interviewing. This format may have been anxiety-provoking for some participants, especially given the processing, memory, and communication difficulties associated with several neurological conditions. Moreover, some participants mentioned having social anxiety in unfamiliar settings. Nonetheless, member-checking, in addition to inviting the participants to email us information they may have forgotten, mitigated the potential repercussions of these issues.

Directions for Future Research

As per my limitations, future research might seek to gather and triangulate data via more inclusive methods than semi-structured interviews alone, such as via participant journaling. Neurodiverse participants in future studies can also be better prepared for interviews to reduce potential anxiety. This might be achieved by providing them the interview schedule in advance to allow them the opportunity to reflect on some of their experiences and potential answers.

Future studies should also seek to have more inclusive sampling. Whilst research has found worrying outcomes for ‘women’ and ‘females’ with ADHD, the discrepancy and often vague definition of these terms has made it hard to decipher what populations might be implicated from these findings. Whilst this study attempted to bridge this gap by sampling AFAB adults, future researchers should explore the experiences of transgender women and other potentially neglected demographics. This can assist in further hypothesising if and how socio-environmental versus physiological factors might inform the experiences of adults with ADHD.

Conclusion

This study determined different ways AFAB university students with ADHD function interpersonally. The findings depicted that they experience significant barriers to receiving social support as seen via frequent invalidation and isolation in their relationships. Moreover, the participants were often very accommodating of loved ones, despite others generally not extending this same understanding to them. As such, the participants seemed to oscillate between trying to be seen and understood, and trying to survive socially, despite the often-harmful implications of camouflaging and muting their needs. This study thus highlighted that the well-being of AFAB adults with ADHD depends greatly on the quality of their interpersonal relationships. This population would benefit from more relationships characterised by mutual and reciprocal understanding and support.

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Appendix A: Participant Documents

Informed Consent Form

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF PSYCHOLOGY
CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Study Titles:

ADHD and Interpersonal Relationships: Exploring the Lived Experiences of AFAB University Students in South Africa

and

Experiences of camouflaging among university students with ADHD in South Africa who were assigned female at birth

RESEARCHERS: Reitumetse Malefane and Estelle Prinsloo
SUPERVISOR: Dr Maxine Spedding

Dear _______________

You are being invited to participate in a research study being led by a team of researchers from the Department of Psychology at the University of Cape Town (UCT). The purpose of this study is to understand more about the lived experiences of university students assigned female at birth (AFAB) in South Africa who have been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). The reason we want to know more about this topic is because it is a severely under-researched area, especially locally, and the knowledge gained can lead to positive developments in ADHD literature and diagnosis. Participating in this study is entirely voluntary. You are under no obligation to participate and there will be no consequences if you decide to discontinue your participation.

Why are you being asked to participate?

You are being asked to participate because it is believed that your lived experiences as an AFAB person who has been diagnosed with ADHD will provide the information needed to answer the research questions.

What does participation involve?

Should you agree to take part in this study, you will participate in an individual interview with one of the researchers in the research team (i.e., either Estelle or Reitumetse). The interview will include questions related to your lived experiences and will last approximately 45 to 60 minutes. Once initial data analysis has been completed, the researchers will contact you via email to check if they have adequately conveyed what you said in the interview. Here, you are free to comment on the accuracy of these findings and make corrections if necessary (referred to as member-checking).

What will it cost to participate?

While there are no direct costs associated with participating in the study, participation will take approximately 60 to 90 minutes of your time, including travel time. If you opt for an in-person interview, this will be held on UCT's Campus, accessible to students for free via the Jammie Shuttle Service. Alternatively, interviews will be conducted online, and you may incur costs related to data or wi-fi.

What will you get in return?

In exchange for your participation, you will stand a chance to win a R500 Takealot voucher. Participants who are interested will be entered into a raffle where one will be randomly selected to receive this voucher.

What are the risks associated with participating?

While most people enjoy interviews like this, some participants may find that talking about their experience of ADHD is distressing. You are free to choose not to answer a particular question if you prefer not to, or you can stop the interview at any time. Again, there will be no consequences for you in these instances. If you do find that participating in this study has made you feel uncomfortable or has brought up difficult or painful feelings, please let us know so that we can talk about what kind of support you might need. In any event, we will provide you with a list of possible resources that you can contact if you would like to.

Are there any benefits to participating?

While there are no guaranteed direct benefits to you as a participant, we hope that the information gathered in this study will help us understand more about the experiences of adult AFABs living with ADHD.

How will your identity and information be protected?

The interview will be audio-recorded and transcribed. This is to ensure that we are able to provide as accurate a representation as possible of what you tell us. The recording will be stored in a password protected folder in One Drive that only the researchers have access to until it has been transcribed. After transcription, the recording will be permanently destroyed. All of your identifying data will be removed from the transcription and you will be assigned a pseudonym.

The information that you provide us in the interviews will be used to write master's theses, and may be published in an academic journal. From time-to-time, the popular media also takes an interest in the research that we produce. However, all of your identifying information, including your name and any other information that makes you identifiable to someone else, will not appear in this research report or in any publications.

What happens if you change your mind about participating?

Participation in the study is entirely voluntary, which means that you are welcome to change your mind and there will be no consequences for you. If you decide to participate in the research project, you can decide to stop at any time and you will not need to provide any explanation for why you would like to stop.

If you have questions about the study, please feel free to contact the following people:

Reitumetse Malefane (Researcher): 0767515309 / MLFREI002@myuct.ac.za
Estelle Prinsloo (Researcher): 0726219970 / PRNEST002@myuct.ac.za
Dr Maxine Spedding (Supervisor): 021 650 3452 / maxine.spedding@uct.ac.za

If you have any questions, comments or complaints about your rights as a study participant, please contact Ms Rosalind Adams at the Department of Psychology, University of Cape Town: 021 650 3417 or rosalind.adams@uct.ac.za

I ___________________________ (name) have read the information contained in the consent form and I am satisfied with my understanding of the study, the possible benefits, risks and alternatives. My questions about the study have been answered to my satisfaction. I hereby voluntarily consent to participate in the research study as described. I have been offered copies of this consent form.

Signature of Participant: ___________________________ Date: ________________

Signature of Researcher: ___________________________ Date: ________________

I give permission for my interview to be recorded with an audio recorder to assist the interviewer with remembering the information.

Name of Participant (Printed): ____

Signature of Participant: ____________________________ Date: ________________

Study Information Sheet

Estelle Prinsloo and Reitumetse Malefane

Dear prospective participant,

We are Year One Clinical Psychology Master's students at the University of Cape Town (UCT) and are conducting research for our dissertations. We are interested in similar topics and are collaborating in the data collection phases of our studies. Our studies are titled:

"Experiences of camouflaging among female university students with ADHD in South Africa" (Estelle) and "ADHD and Interpersonal Relationships: Exploring the Lived Experiences of Female University Students in South Africa" (Reitumetse).

We are interested in the lived experiences of students assigned female at birth (AFAB) who have been diagnosed with ADHD. Estelle is specifically interested in the role of camouflaging in ADHD's presentation in AFAB university students and Reitumetse is interested in the impact of ADHD on the interpersonal relationships on this population group.

If you qualify for the study, you will be expected to participate in an online or in-person interview, which will last approximately 60 minutes. You will be interviewed by either Estelle or Reitumetse and you will be asked questions that pertain to both of our studies. The interviews will be transcribed by us, and we will have access to each other's transcripts. Our supervisor, Dr Maxine Spedding, will also have access to the data we collect.

To qualify, you have to be an AFAB student who was diagnosed with ADHD by a medical or mental health professional, be over the age of 18 years and be registered at UCT in 2023. You can choose to be entered into a raffle for a R500 Takealot voucher. Alternatively, relevant to psychology students, you can opt to receive 2 SRPP points for participating in the interview, and another point for participating in the member checking process (3 points in total). The latter will involve you reading a summary of our analysis of our interview with you and for you to provide feedback on whether you agree or resonate with our findings.

If you are still interested, we can send you the informed consent form which you will need to complete and return to us should you be interested in participating.

Kind regards,

Estelle and Reitumetse

Debriefing Letter

Estelle Prinsloo and Reitumetse Malefane

Dear prospective participant,

Should you find discussing certain experiences and memories during the interview distressing, you will be given an opportunity to debrief with the researcher interviewing you at the end of the session. Should you want or need additional support, we have made a resource list comprised of free and low-cost counselling and support services available to you.

Regards,

Estelle and Reitumetse

Resource List

ADHD SUPPORT

RESOURCE LIST

FREE TELEPHONE COUNSELLING

- Lifeline Cape Town: 021 461 1113 / 063 709 2620
- Lifeline National (24/7): 0861-322-322
- SADAG: 011 234 4837

UCT STUDENT WELLNESS SERVICE

- Counselling services available for students: https://uct.ac.za/dsa/student-wellness-service-counselling-services/counselling-services-sws

SUPPORT GROUPS

- SADAG Support Group for Young Adults: ilhaampk@gmail.com
- Maitland / Kensington ADHD Support Group: 082 899 1891

ONLINE RESOURCES

- Additude Magazine: https://www.additudemag.com/
- ADHD South Africa: https://m.facebook.com/groups/696361647197068/?ref=share&mibextid=S66gvF

Appendix B: Participant Recruitment Advertisement

CALL FOR PARTICIPANTS!

Female university students' experiences of living with ADHD

WHO ARE CONDUCTING THE STUDIES?

Estelle Prinsloo and Reitumetse Malefane, Year One Clinical Psychology Masters Students at UCT

PURPOSE OF THE STUDIES

To better understand how ADHD symptoms present in females and how ADHD impacts on their relationships and social interactions

WHAT IS EXPECTED OF PARTICIPANTS

Participants are expected to participate in individual, semi-structured interviews, which will be conducted by one of the researchers

QUALIFYING CRITERIA

-Assigned female at birth (i.e., your assigned sex at birth was female. All genders welcome)
-Registered student at UCT
-Diagnosed with ADHD by a medical or mental health professional

If you qualify and you are interested in participating, email MLFREI002@myuct.ac.za for more information

Bonus: Participants stand a chance of winning a R500.00 Takealot voucher

Appendix C: Interview Schedule

Opening (Reitumetse):

My name is Reitumetse Malefane and I am a Clinical Psychology masters student. I am conducting a research study on ADHD in AFABs in collaboration with my classmate Estelle Prinsloo, although our topics slightly differ. My interest lies in the ways ADHD affects interpersonal relationships and Estelle is focused on ADHD and the concept of camouflaging. Both of us have been diagnosed with ADHD, which is partly where our interest in these topics stem from. I will be asking you questions that aim to address both of our topics. Please read the following consent forms and let me know if you need clarity on anything before signing and before we can begin. Thank you for your interest in participating.

Opening (Estelle):

My name is Estelle Prinsloo, and I am a Clinical Psychology Masters student. I am conducting a research study on ADHD in AFABs in collaboration with my classmate Reitumetse Malefane, although our topics slightly differ. My interest lies in ADHD and the concept of camouflaging and Reitumetse's study is about how ADHD affects interpersonal relationships. Both of us have been diagnosed with ADHD, which is partly where our interest in these topics stems from. I will be asking you questions that aim to address both of our topics. Please read the following consent forms and let me know if you need clarity on anything before signing and before we can begin. Thank you for your interest in participating.

1. Can you tell me more about your ADHD diagnosis?
    a. Probes: When were you diagnosed?
    b. What led to the diagnosis?
    c. Who diagnosed you?
2. Have you ever been diagnosed with another mental health condition?
    a. Probes: Is this a current diagnosis?
    b. Any (prior) incorrect diagnoses?
3. If you know, what type of ADHD do you have (i.e., inattentive, hyperactive-impulsive, or combined-type)?
4. What do you know about your diagnosis?
    a. Probes: What are your main symptoms / what do you understand are your main symptoms?

5. Are you receiving or have you ever received any psychological or psychiatric treatment for ADHD?
    a. Probes: If so, how have you experienced treatment?
6. Do you have family members or loved ones with the diagnosis or any other mental health diagnosis?
    a. Probes: If yes, tell me more about who and what condition they have.
7. How often do you disclose your diagnosis to others and how readily do you do so to strangers?
    a. Probe: (If participant doesn't disclose) Can you tell me more about why you do not disclose your diagnosis?
8. How do you think having ADHD might have affected you on an emotional level?
    a. Probes: Do you have feelings of shame regarding your symptoms? (tell me more)
    b. Has ADHD affected your self-esteem? (tell me more)
    c. Do you feel sensitive to rejection? (tell me more)
    d. Do you perceive yourself to be short-tempered? (tell me more)
    e. Do you have feelings of anxiety or social anxiety? (tell me more)
9. Can you tell me about your ADHD symptoms growing up (during childhood)?
    a. Probes: How did your symptoms manifest at home?
    b. How did your symptoms manifest at school?
    c. How did your symptoms manifest with friends/socially?
10. Can you tell me about your symptoms now?
    a. Probe: Use an example of a symptom they mentioned in the previous question and ask if the symptom is still as severe, or if manifestation has changed.
11. To what extent do you think ADHD has impacted your relationships?
    a. Probes: Has your ADHD/ ADHD symptoms ever become a source of tension? (directly or indirectly – an example of the latter: academic performance causing tension with parents).
    b. Have you ever been celebrated for some of your ADHD traits? (tell me more)
12. How much support and understanding do you receive from loved ones or others in your life?

    a. Probes: Please tell more about who your support structures are (online communities/friends with ADHD, family and friends, mental health communities, support groups etc.)?
    b. How do they support you?
    c. If limited/no support, what do you think might be different about your life if you had more support? Please expand.
    d. Has there been resentment built to those who didn't understand/support you?

13. Can you tell me more about your romantic life?
    a. Probes: Current relationship status? Dating history?
    b. Refer to previous answers about others in their life and ask if the same applies to romantic partners.
14. How much do you perceive the people in your life to have understood your diagnosis?
    a. Probes: Have you ever felt misunderstood? (tell me more)
    b. Have you ever experienced any negative treatment because of your diagnosis? (tell me more)
    c. Have you felt that you are treated differently than people without ADHD? If so, who (e.g., siblings, peers at school etc.)? (tell me more)
    d. Have you ever felt yourself being compared to others or have you compared yourself to others (without ADHD)? (tell me more)
15. How do you perceive people in your community/ environment to understand ADHD?
16. Have you heard of the term camouflaging in relation to ADHD? If so, how do you understand this term?
    a. Probes: (If they say no, define). Definition: Camouflaging refers to behaviours and strategies that people with ADHD use to compensate cognitively, hide certain behaviours (masking), and fit in socially. So, camouflaging refers to all these behaviours and strategies. For example: perfectionist work behaviours, rehearsing conversations before they occur, forcing yourself to sit still, making eye contact, making sure you don’t talk too much etc.)
17. In what ways do you think you camouflaged your ADHD as a child?
    a. Probes: Why do you think you camouflaged your ADHD?

   b. What do you think would have happened if you did not camouflage your ADHD?
   c. When you think of your symptoms, did you only camouflage some of them, or all of them?
   d. Did the context you were in influence whether you would camouflage or not, i.e. at school, home, social situations etc.?

18. In what ways do you camouflage your ADHD now (as a young adult)?
    a. Probes: (If they mentioned a difference in their symptoms between childhood and now, ask them): In what ways do you think your symptoms presenting differently now has to do with camouflaging?
    b. Have the strategies you use changed over time / as you have gotten older?
19. Why do you think you continue to camouflage your ADHD?
    a. Probes: What do you think would happen if you stopped camouflaging your ADHD?
    b. Do you feel you are expected to act neurotypical, or “normal”? (tell me more)
20. Tell me about the cognitive, emotional and physical impact of camouflaging.
21. Tell me about the advantages of camouflaging.
22. Is there anything else that you would like to share about how having ADHD has shaped you as a person / your life?

Researcher Contributions to Interview Schedule

Questions 1-6: Joint

Question 7: Reitumetse

Question 8: Joint

Questions 9-10: Estelle

Questions 11-15: Reitumetse

Questions 16-21: Estelle

Question 22: Joint

Appendix D: Audit-trail

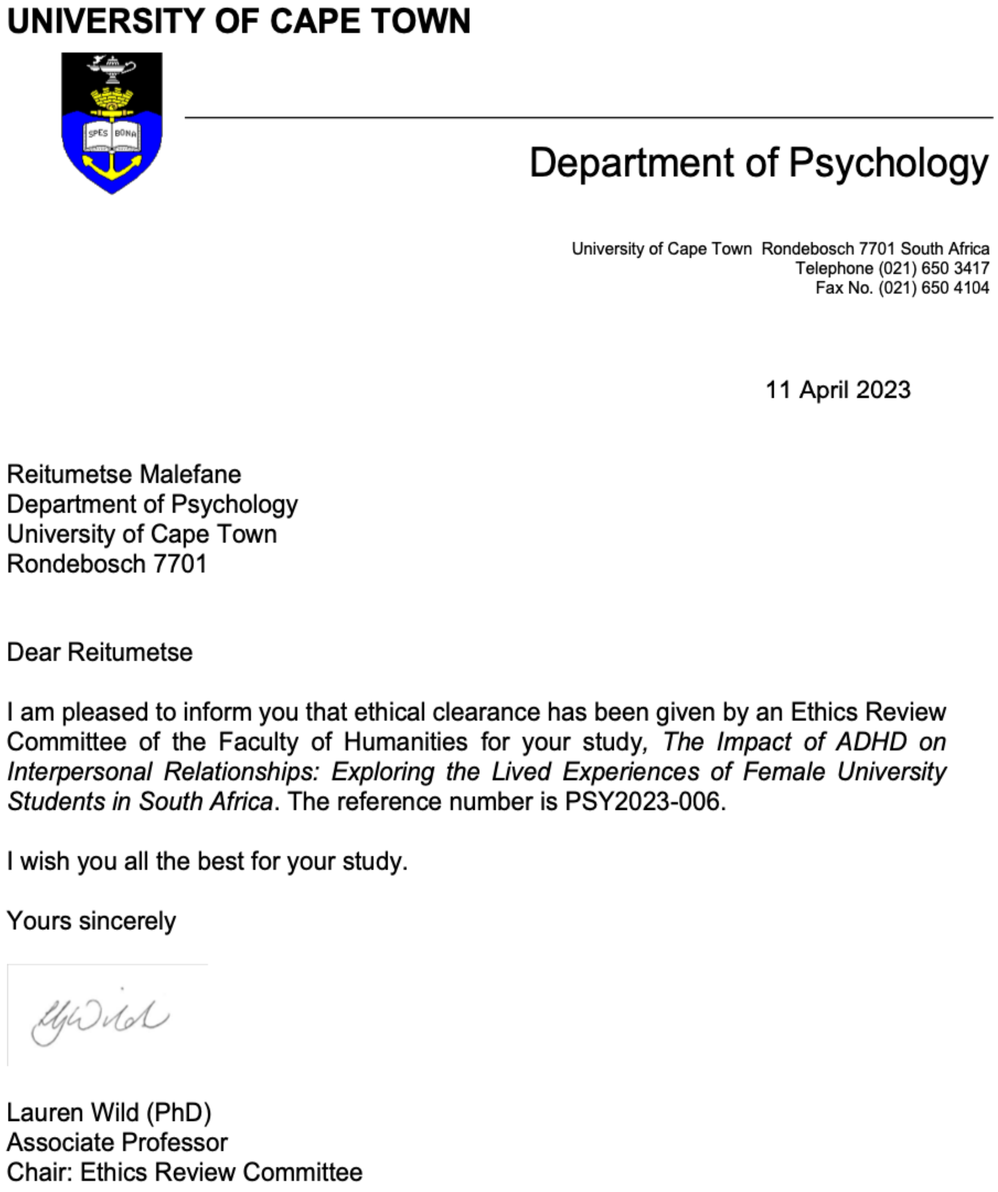
Table 3

Examples of Thematic Analysis Procedure

Transcript excerpt	Member-checking excerpt	Codes	Themes
Amy: I think when I first got diagnosed, it was definitely, I just like, um, went into, like, a rabbit hole. I was like, "Okay, I'm gonna listen to *every single* ADHD podcast, and I'm gonna read *every single* book!". Like, genuinely, for like, months, like, like *everything* I could tune, was about ADHD, like, my poor, like, friends just, heard of it so much!	**I:** How do friends react when you 'info dump'? And how does this make you feel? **Amy:** A lot of my friends now are ADHD or are just very supportive of me, and so don't judge me for it. My mom can be quite judgemental about it … so I've stopped opening up as much to her. I think I've found the spaces where I know I feel safe to share, but also am always quite aware of body language stuff so will stop if it feels like too much.	Attention to others' perceptions Vigilance of others' body language Adapting behaviour to avoid annoying others Finding safety in similar people	**Main Themes:** Compromised closeness and vulnerability Strategising to find connection **Sub-themes:** Vigilance of others' perceptions Feeling judged and misunderstood Finding similar people
Toni: … if I say that I have ADHD, people are like, "Shouldn't you be, like, jumping off the walls?". … they have a very much childlike view of what ADHD is. So, I don't think it's as easy to find a group of neurotypical people and just be like, "Oh, I have ADHD" and they be like, "Oh, okay. I understand".	**I:** Have you found making friends with neurotypical people difficult? **Toni:** I wouldn't say it's difficult to be friends with neurotypical people exactly, it's rather difficult being close to people who are unfamiliar and unaware or have a misunderstanding about neurodivergent people, whether they themselves may be neurodivergent themselves and are unaware of it.	Connecting with people who understand neurodivergence Valuing being understood Feeling misunderstood/ invalidated due to ADHD stereotypes	**Main Themes:** Compromised closeness and vulnerability Strategising to find connection **Sub-themes:** Feeling judged and misunderstood Finding similar people

Note. "I:" indicates 'interviewer', thus indicating the clarification questions I asked.

Appendix E: Ethical Approval Documents



UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

11 April 2023

Reitumetse Malefane
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Reitumetse

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *The Impact of ADHD on Interpersonal Relationships: Exploring the Lived Experiences of Female University Students in South Africa*. The reference number is PSY2023-006.

I wish you all the best for your study.

Yours sincerely

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

Faculty of Humanities
Postgraduate Administration
University of Cape Town

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Website:http://www.humanities.uct.ac.za/hum/postgraduate/studies/aboutus/overview

12 April 2023

Ms Reitumetse Malefane
E-mail: MLFREI002@MYUCT.AC.ZA
Student no: MLFREI002

Dear Ms Reitumetse Malefane

ACCEPTANCE OF MASTERS PROPOSAL BY HUMANITIES FACULTY BOARD

I have pleasure in advising that your research proposal as detailed below has been approved by the department, and the Faculty of Humanities in the Dean's Circular HUM 03/2023.

Kind regards
Ibtishaam.Jacobs@uct.ac.za
Miss Ibtishaam Jacobs
Faculty of Humanities: Postgraduate office

cc Supervisor: Dr M Spedding

RESEARCH ACCESS TO STUDENTS — DSA100

NOTES

1. This form must be **FULLY** completed by all applicants who want to access UCT students for the purpose of research or surveys.
2. Return the fully completed **(a) DSA 100** application form **by email**, in **the same word format**, together with **your: (b) research proposal inclusive of your survey, (c) copy of your ethics approval letter / proof (d) informed consent letter** to: Nadierah.Pienaar@uct.ac.za. You application will be attended to by the Executive Director, Department of Student Affairs (DSA), UCT.
3. The turnaround time for a reply is **approximately 10 working days**.
4. NB: It is the responsibility of the researcher/s to apply for and to obtain **ethics approval and to comply with amendments that may be requested;** as well as **to obtain** approval to access UCT staff and/or UCT students, from the following, at UCT, respectively:
   (a) **Ethics**: Chairperson, Faculty Research Ethics Committee' (FREC) for ethics approval, (b) **Staff access:** Executive Director: HR for approval to access UCT staff, and (c) **Student access:** Executive Director: Student Affairs for approval to access UCT students.
5. **Note:** UCT Senate Research Protocols requires compliance to the above, **even if prior approval has been obtained from any other institution/agency. UCT's research protocol requirements applies to *all* persons, institutions and agencies from UCT and external to UCT who want to conduct research on human subjects for academic, marketing or service related reasons at UCT.**
6. **Should approval be granted to access UCT students for this research study, such approval is effective for a period of one year from the date of approval (as stated in Section D of this form), and the approval expires automatically on the last day.**
7. **The approving authority reserves the right to revoke an approval based on reasonable grounds and/or new information.**

SECTION A: RESEARCH APPLICANT/S DETAILS

Position	**Staff / Student No**	**Title and Full Name**	**Contact Details (Email & Cell / Land line)**
A.1 Student Number	**MLFREI002**	**Mx. Reitumetse Malefane**	**malefane.tumi@gmail.com/ 0767515309**
A.2 Academic / PASS Staff No.			
A.3 Visitor/ Researcher ID No.			
A.4 University at which a student or employee	**University of Cape Town**	**Address if *not* UCT:**	
A.5 Faculty & Department/School	**Faculty of Humanities, Department of Psychology**		
A.6 APPLICANTS DETAILS	**Title and Name**	**Tel.**	**Email**
If different from above			

SECTION B: RESEARCHER/S SUPERVISOR/S DETAILS

Position	**Title and Name**	**Tel.**	**Email**
B.1 Supervisor	**Dr Maxine Spedding**	**021 650 3425 / 0829290184**	**maxine.spedding@uct.ac.za**
B.2 Co-Supervisor/s			

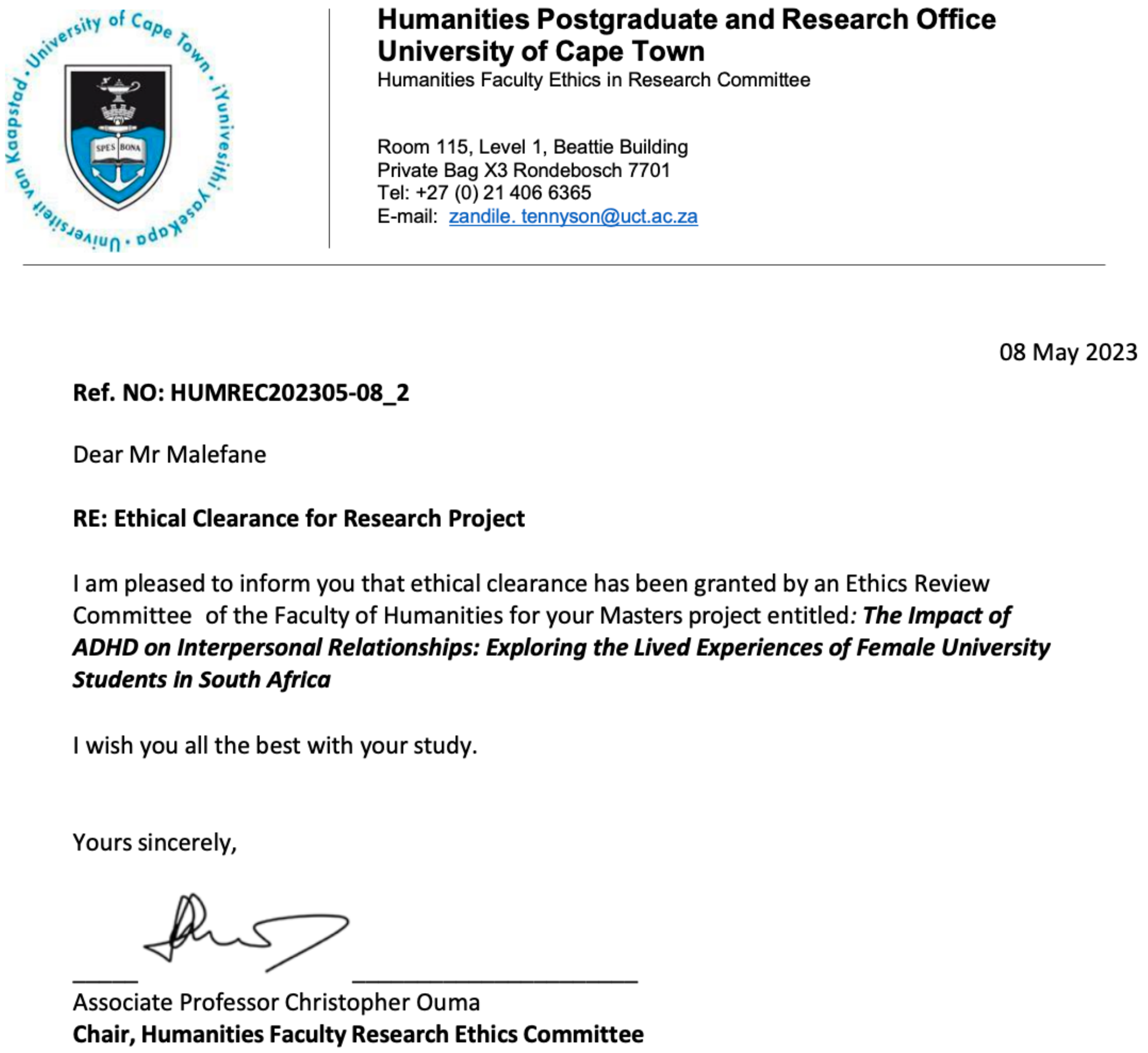
SECTION C: APPLICANT'S RESEARCH STUDY FIELD AND APPROVAL STATUS

C.1 Degree – if applicable	**Master of Arts in Clinical Psychology**
C.2 Research Project Title	**The Impact of ADHD on Interpersonal Relationships: Exploring the Lived Experiences of Female University Students in South Africa**
C.3 Research Proposal	**Attached: Yes ☒ No ☐**
C.4 Target population	**University students assigned female at birth (AFAB) [i.e., their sex assigned at birth, thus allowing all genders to participate should they have been AFAB], studying psychology at UCT, with an ADHD diagnosis from a qualified health professional.**
C.5 Lead Researcher details	**If different from applicant:**
C6. Will use research assistant/s	**Yes ☐ No ☒** **If yes- provide a list of names, contact details :**
C.7 Research Methodology and Informed consent	**Research methodology:** Interpretive phenomenological approach, semi-structured interviews.. **Informed consent:** Yes, consent forms provided to participants.
C.8 Ethics clearance status from UCT's Faculty Ethics in Research Committee /Chair (EiRC)	**Approved by the UCT EiRC: Yes ☒ With amendments: Yes ☒ No ☐** **(a) Attach copy of your UCT ethics approval. Attached: Yes ☒ No ☐** **(b) State date / Ref. No / Faculty of your UCT ethics approval: 11/04/2023 Ref. / Faculty: PSY2023-006**

SECTION D: APPLICANT/S APPROVAL STATUS FOR ACCESS TO STUDENTS FOR RESEARCH PURPOSE

(To be completed by the ED, DSA or NOMINEE)

D.1 APPROVAL STATUS	**Approved / With Terms / Not** **(i) Approved ☒** **~~(ii) With terms~~** **~~(iii) Not approved~~**	*** Conditional approval with terms** **a) Access to students for this research study must only be undertaken after written ethics approval has been obtained.** ***b)* In event any ethics conditions are attached, these must be complied with before access to students.**		**Applicant/s Ref. No.:** **MLFREI002 / Mx Reitumetse Malefane**
D.2 PREPARED BY:	**Designation**	**Name**	**Signature**	**Date of Approval**
	Personal Assistant	***Nadierah Pienaar***	Pienaar	**20/04/2023**
D.3 APPROVED BY:	**Designation**	**Name**	**Signature**	**Date of Approval**
	Executive Director Department of Student Affairs	***Mr Pura Mgolombane***		***20/04/2023***



Humanities Postgraduate and Research Office
University of Cape Town
Humanities Faculty Ethics in Research Committee

Room 115, Level 1, Beattie Building
Private Bag X3 Rondebosch 7701
Tel: +27 (0) 21 406 6365
E-mail: zandile. tennyson@uct.ac.za

08 May 2023

Ref. NO: HUMREC202305-08_2

Dear Mr Malefane

RE: Ethical Clearance for Research Project

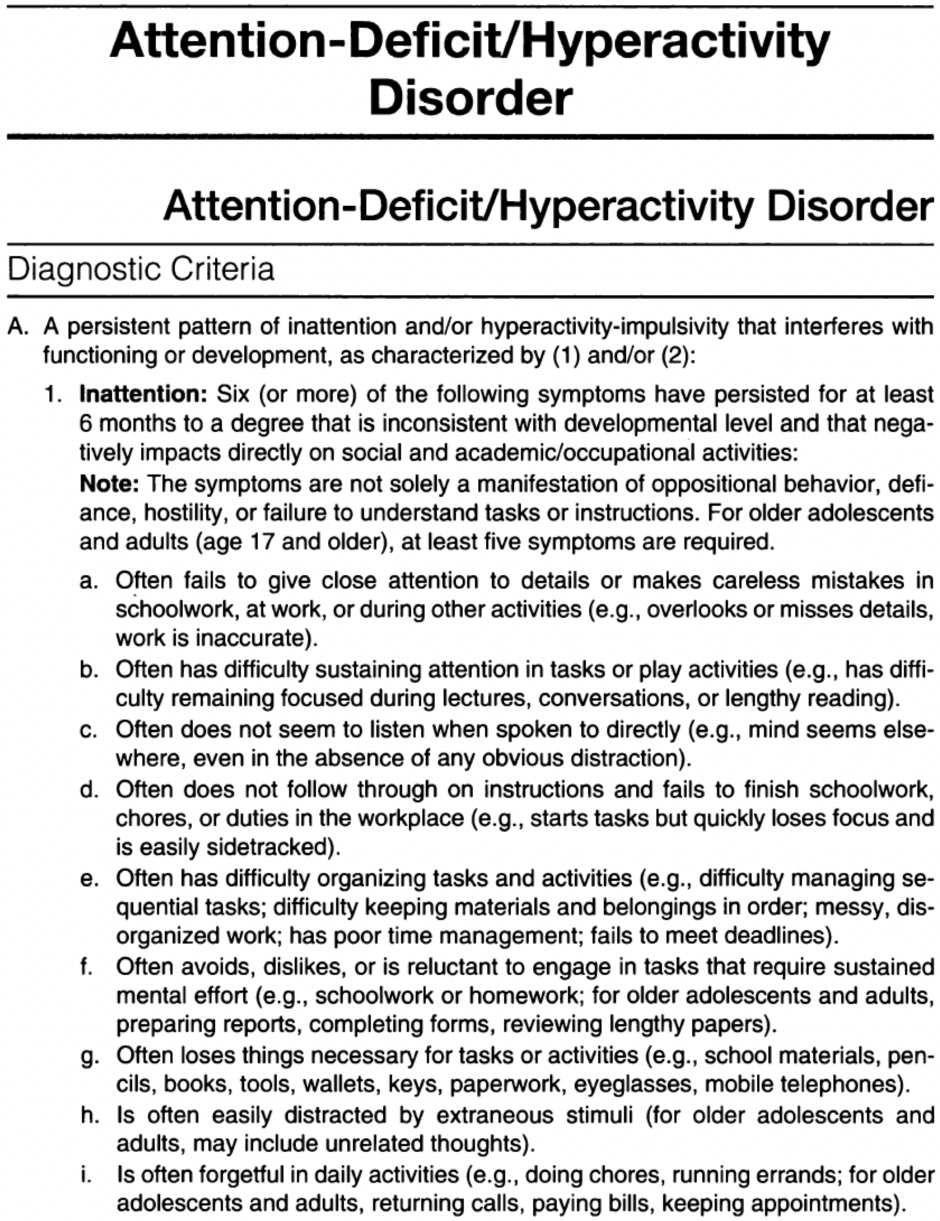
I am pleased to inform you that ethical clearance has been granted by an Ethics Review Committee of the Faculty of Humanities for your Masters project entitled***: The Impact of ADHD on Interpersonal Relationships: Exploring the Lived Experiences of Female University Students in South Africa***

I wish you all the best with your study.

Yours sincerely,

Associate Professor Christopher Ouma
Chair, Humanities Faculty Research Ethics Committee

Appendix F: Diagnostic Criteria of Attention-Deficit/Hyperactivity Disorder



Attention-Deficit/Hyperactivity Disorder

Attention-Deficit/Hyperactivity Disorder

Diagnostic Criteria

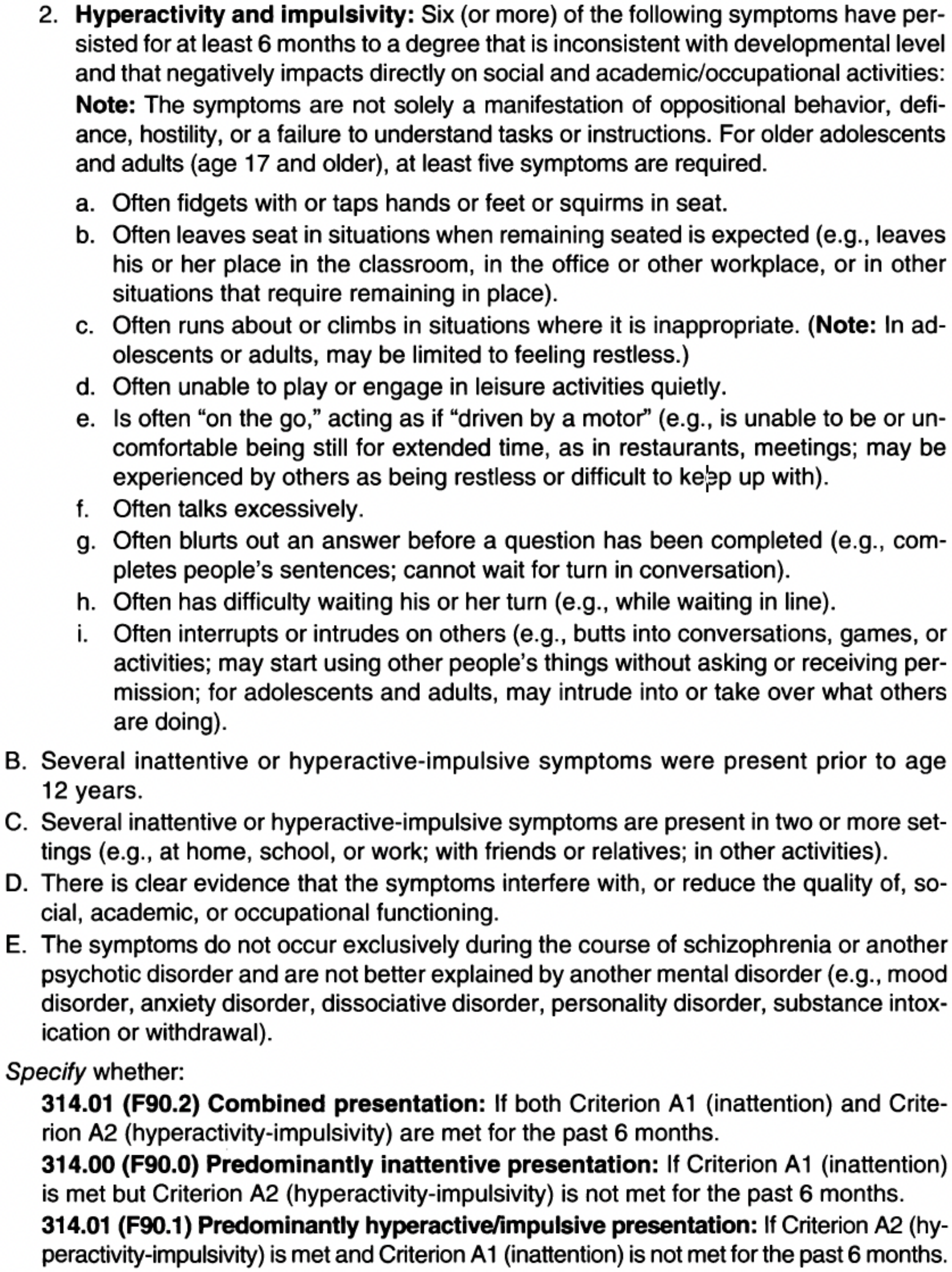
A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. **Inattention:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

   Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

   a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
   b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
   c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
   d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
   e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
   f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
   g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
   h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
   i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Note. Taken from page 59 of the Diagnostic and Statistical Manual of Mental Disorders fifth edition, https://doi.org/10.1176/appi.books.9780890425596 (APA, 2013, p. 59).



2. **Hyperactivity and impulsivity:** Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
   Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
   a. Often fidgets with or taps hands or feet or squirms in seat.
   b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
   c. Often runs about or climbs in situations where it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)
   d. Often unable to play or engage in leisure activities quietly.
   e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
   f. Often talks excessively.
   g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
   h. Often has difficulty waiting his or her turn (e.g., while waiting in line).
   i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:

314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

Note. Taken from page 60 of the Diagnostic and Statistical Manual of Mental Disorders fifth edition, https://doi.org/10.1176/appi.books.9780890425596 (APA, 2013, p. 60).