Enough and Ongoing: Reimagining Supervision Through a Shame-Sensitive, Neuroaffirming Lens

by

Freya S. Wasteneys

A capstone submitted in partial fulfillment

of the requirements for the Degree of

Master of Counselling (MC)

City University in Canada

Vancouver, BC

May 2025

APPROVED BY

Maria Stella, Ph.D., R.C.C., Capstone Supervisor, Master of Counselling Faculty

Jill Taggart, Ph.D., R.C.C.- A.C.S., Faculty Reader, Master of Counselling Faculty

School of Health and Social Sciences

Abstract

Shame is a pervasive but often overlooked component of the lived experience of ADHD, shaped by chronic invalidation, masking, and pressure to meet normative expectations around behaviour, productivity, and self-regulation. This capstone explores how shame-based coping strategies emerge and persist in individuals with ADHD and how therapy and supervision can either reinforce or interrupt these patterns. Through a literature review grounded in Shame Resilience Theory, neuroaffirming practice, and relational-cultural and feminist frameworks, this project examines the emotional and systemic roots of ADHD-related shame. Particular attention is given to supervisory dynamics—how masking, over-functioning, and emotional suppression often continue in the training and supervisory process, mirroring the conditions that created shame in the first place. Drawing on clinical reflection, supervision research, and narrative-informed models, this project offers a framework for shame-sensitive, neuroaffirming supervision. Six guiding principles are proposed to support supervisors in fostering relational safety, identity integration, and emotional sustainability. Implications for graduate training programs and supervisory culture are discussed, with a call to reimagine supervision as a site of transformation rather than performance. This project contributes to a growing body of work advocating for counselling approaches that are not only neurodivergent-affirming but also shame-literate, reflexively engaged, and emotionally sustainable for both clients and clinicians.

Keywords: ADHD, counselling training, neurodivergence, shame, supervision.

Dedication or Acknowledgement

Written and reflected within the ancestral, traditional and unceded territory of the K'ómoks, consisting of the Pentlatch, Ieeksan (eye-ick-sun), Sasitla (sa-seet-la), and Sathloot (sath-loot) people.

I dedicate this Capstone to:

The creative thinkers.

The neurodivergent practitioners, supervisors, and educators.

The folks who worry they are too much.

The ones who wonder if they are enough.

And all the people who have offered me support along the way.

Table of Contents

Abstract 2

Dedication or Acknowledgement 3

Table of Contents 4

Chapter 1: Introduction 8

Overview of the Topic 8

Purpose Statement 10

Theoretical/Conceptual Framework 11

Contribution to the Field 12

Reflectivity and Positionality Statement 13

ADHD (Attention Deficit Hyperactivity Disorder) 17

Burnout 18

Deficit-Based Language 18

Executive Dysfunction 18

Masking 18

Neuroaffirming Therapy 18

Over-adaptation 19

Parallel Process 19

Rejection Sensitivity Dysphoria (RSD) 19

Shame 19

Self-Compassion 19

Outline of the Capstone Project Chapters 20

Chapter 2: Literature Review 22

Core Mechanisms of Shame in ADHD 23

Executive Dysfunction as Moral Failure 24

Chronic Invalidation and Misunderstanding 26

Rejection Sensitivity and Emotional Intensity 27

Late Diagnosis and Systemic Messaging 28

Coping and the Risk of Over-Adaptation 31

Masking and Camouflaging 31

Perfectionism, Procrastination, and Avoidance 34

Over-Functioning, Burnout, and Emotional Collapse 36

Navigating Shame Dynamics for ADHD Individuals in Therapy and Supervision 39

Deficit-Focused Language and Productivity Bias 39

Masking in the Therapy Room 42

Parallel Process and Countertransference 44

Supervision as a Shame Site or Healing Space 46

The Journey Towards Self-Compassion: Barriers and Pathways 49

Barriers: Compassion as Threat and Therapy as Exposure 49

Pathways: Fostering Self-Compassion, Connection and Creative Integration 51

Summary 55

Chapter 3: Discussion and Application 58

Discussion of Findings 58

Shame as Parallel Process 58

Masking and Over-Adaptation Beyond the Therapy Room 59

Challenging the Constraints of Traditional Professionalism 60

Gaps in the Literature 61

Applications 63

Grounding in Existing Supervisory Models 64

Principles of Shame-Sensitive, Neuroaffirming Supervision 66

Reframe Supervision as Relational and Reparative 67

Recognise and Gently Disrupt Masking and Over-Functioning 67

Model a More Expansive Understanding of Professionalism 68

Integrate Emotional and Identity Work into Supervision 68

Supervise with Intersectionality and Positionality in Mind 69

Support Narrative Re-Authoring and Identity Integration 69

Implications for Training Programs and Supervisory Culture 69

Conclusion 72

References 74

Chapter 1: Introduction

The experience of Attention Deficit Hyperactivity Disorder (ADHD) is often framed through the lens of behavioural symptoms and cognitive deficits—disorganization, inattention, hyperactivity, or impulsivity. But for many—especially those diagnosed later in life—the most enduring impact is emotional. Shame, shaped by years of misattunement, criticism, and performance pressure, often lingers beneath the observable executive dysfunction. While clinical models focus on management of external symptoms to indicate success of treatment, it is this quieter emotional undercurrent that has the biggest impact over time. This project explores how shame is woven into the experience of ADHD and how counselling and supervision can either interrupt or reinforce shame-based coping patterns.

Overview of the Topic

According to the *DSM-5-TR*, ADHD is defined as "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (APA, 2022, p. 59). While this diagnostic lens provides a structured framework for assessment, it centres observable behaviours and often overlooks the emotional and relational toll of the disorder. Barkley (1997, 2021) reframes ADHD as a condition rooted in impaired self-regulation—including working memory, internal speech, emotional control, and behavioural inhibition. These deficits are frequently misinterpreted as laziness or personal failure, particularly when individuals struggle in environments that reward productivity, precision, and emotional control.

For many, these experiences manifest as shame. Brown (2006) defines shame as "the intensely painful feeling or experience of believing we are flawed and therefore unworthy of love and belonging" (p. 45). In a qualitative study by Beaton et al (2022), adults with ADHD described feeling "brittle," "pitiful," and "stupid/lazy"—language that mirrored the criticism they

received from others and was at times “traumatic” (p. 6). This internalised shame is more than emotional distress—it is functionally limiting. In a second study, Beaton et al. (2022) found that lower self-compassion in adults with ADHD significantly predicted higher distress and lower well-being. As they write, “the way in which adults with ADHD respond to themselves during times of suffering or failure” helps explain the mental health gap between those with and without ADHD (p. 2506).

These dynamics are shaped by context. Luo et al. (2019) describe ADHD as “a heterogeneous disorder,” with diverse clinical presentations, developmental trajectories, and comorbidities (p. 2). Women and gender-diverse individuals are often diagnosed later—if at all—due to internalised presentations and high masking demands (Huynh et al., 2024). Late diagnosis can bring clarity, but it often arrives with grief and regret. As Bowers and Widdowson (2023) note, diagnosis may bring up “sadness over missed opportunities and years of being pathologised and misunderstood” (p. 33).

In response to these pressures, many individuals with ADHD develop adaptive strategies that can have a cost over time: masking, striving, or pushing past limits to maintain a sense of competence. These behaviours are often praised externally but can lead to emotional collapse and burnout (Bowers & Widdowson, 2023; Nyström et al., 2020; Brattberg, 2006). Ironically, therapy itself can reinforce these dynamics when it emphasizes symptom reduction without attending to shame. As Bowers and Widdowson (2023) observed, “Clients’ ‘behaviour’ would be observed first, and the underlying need for connection would be missed” (p. 33).

This capstone explores how shame operates in the lived experience of ADHD—how it shapes identity and coping, and how it plays out in therapeutic and supervisory relationships. Drawing on Shame Resilience Theory (Brown, 2006) and identity-affirming frameworks

(Chapman & Botha, 2022; Kroll et al., 2024), it considers how counsellors can foster spaces that support not just behavioural change, but emotional safety, authenticity, and connection.

Purpose Statement

The purpose of this capstone is to explore how shame shapes coping and identity in individuals with Attention-Deficit/Hyperactivity Disorder (ADHD), and how therapy and supervision can either interrupt or reinforce those patterns. Guided by the central research question—How does shame shape coping and identity in individuals with ADHD, and how can therapy and supervision support healing without reinforcing over-adaptation and burnout?—this project brings together academic research, clinical insight, and lived experience to better understand the emotional and relational dimensions of ADHD that are often overlooked in traditional approaches.

While most ADHD interventions focus on executive functioning or symptom reduction (Barkley, 2021), they often miss the deeper, more invisible experiences of internalized shame, chronic invalidation, and emotional exhaustion (Beaton et al., 2022; Whitman, 2019). For many individuals, these emotional undercurrents contribute to coping strategies such as masking, perfectionism, and over-functioning—strategies that may be praised externally but often come at a personal cost (van der Putten et al., 2024; Bowers & Widdowson, 2023). This capstone seeks to illuminate how these patterns take root and how therapists and supervisors can show up in ways that affirm identity, foster connection, and interrupt shame cycles rather than reinforcing them.

This project is especially intended for counsellors, supervisors, and emerging clinicians—particularly those working with neurodivergent clients or navigating their own neurodivergence. By centering emotional experience and therapeutic dynamics, this capstone contributes to a growing body of work advocating for neurodivergent-affirming, relationally attuned, and shame-

sensitive counselling practices (Chapman & Botha, 2022; Kroll et al., 2024). Ultimately, the goal is to support practitioners in holding space that helps clients move from over-adaptation toward self-compassion and sustainable well-being.

Theoretical/Conceptual Framework

This capstone is informed by an integrative, relational framework that centers the emotional and systemic dimensions of ADHD-related shame. Drawing primarily from Shame Resilience Theory (Brown, 2006), the project explores how shame is internalized through repeated invalidation and can be transformed through connection, compassion, and authenticity. Brown emphasizes the role of empathy and relational safety in disrupting shame cycles—a process especially relevant for ADHD individuals whose identities are often shaped by critical feedback loops within social, educational, and familial systems.

Attachment theory provides an additional lens, highlighting how early relational experiences, particularly those involving chronic misattunement or invalidation, contribute to internal working models of being "too much" or "not enough." For individuals with ADHD—especially those diagnosed late—these patterns often reemerge in therapy and supervision, underscoring the importance of attuned, reparative relationships (Shapiro & Carlson, 2009; Taylor et al., 2006).

A neurodiversity-affirming perspective also underpins this work, rejecting deficit-based models and reframing ADHD as a variation in cognitive and emotional processing. Informed by constructivist and relational-cultural theories, this approach situates identity within social context, recognizing how systemic forces—such as ableism, productivity culture, and colonial narratives of worth—shape internalized shame (Chapman & Botha, 2022). Rather than striving for "normalcy," a neuroaffirming stance supports authentic expression and sustainable coping.

Finally, the capstone draws on theories of parallel process and countertransference to examine how therapist-client and supervisor-therapist dynamics may unconsciously mirror each other, especially in the presence of shame and neurodivergence. These relational enactments offer both risks and opportunities: left unexamined, they may reinforce overcompensation or internalized failure; when held with awareness, they can become sites of reflection, repair, and shared humanity (Zetzer et al., 2020).

Together, these frameworks support a relational, contextual, and anti-oppressive approach to understanding ADHD-related shame, illuminating how healing can occur within therapy and supervision when clinicians attune to both internal and systemic dynamics.

Contribution to the Field

There is no shortage of research on ADHD and emotional distress—rejection sensitivity, self-criticism, and low self-esteem among them—but shame often sits just beneath the surface, referenced indirectly or treated as a secondary issue. Some scholars name it directly (Bernstein, 2015; Bowers & Widdowson, 2023), but it is rarely centered as the relational and systemic force that it is. Even less attention is given to how shame is reinforced or interrupted in the therapy room or in supervision, particularly when dynamics like masking, over-functioning, or productivity bias go unexamined. The pieces are there, but what is often missing in the research is a more integrated, human understanding of how shame threads through identity, coping, and clinical practice in the context of ADHD.

This capstone brings those threads together. It positions shame not as a byproduct of executive dysfunction, but as something central to the lived experience of ADHD—shaped in relationship and deeply tied to how individuals come to see themselves. It also asks what happens when therapists or supervisors inadvertently recreate the very conditions that

contributed to that shame in the first place, and how we might begin to interrupt these patterns to allow for more curiosity and compassion. There is a gap in the literature not only in empirical research, but in how we reflect on the therapist's role, our own neurodivergence, and the parallel processes that unfold in therapy and supervision (Zetzer et al., 2020; Lewis, 2024).

Rather than offering a fixed model, this project proposes a more relational and reflexive lens—one that honours lived experience and helps give a voice to the emotional undercurrents that often go unnamed or are quietly carried by therapists, especially in professional cultures that equate composure with competence. By bridging research with personal insight, this project seeks to support more attuned, identity-affirming, and emotionally sustainable approaches to ADHD therapy and supervision, closing the gap between what we know and how we practice.

Reflectivity and Positionality Statement

My interest in the intersection of ADHD and shame is shaped by both personal lived experience and my emerging identity as a clinician. My diagnosis of ADHD in adulthood allowed me to make sense of longstanding struggles that had often been misinterpreted as laziness, disorganisation, or a lack of effort. These experiences contributed to internalised narratives of failure and patterns of avoidance, perfectionism, and deep-seated shame—patterns I continue to bring curiosity and compassion to and now recognise in many of the clients I work with. While receiving a diagnosis brought clarity, it also carried grief for the years I spent feeling misunderstood. In hindsight, my coping strategies often reflected cycles of over-adaptation—masking difficulties, striving to "prove" myself, and working past capacity to show my competence and worth. These patterns helped me function in the short term but often led to burnout and disconnection from my own needs.

This personal history continues to inform the therapist I am becoming, and how I approach research. Through my clinical work and supervision, I have become increasingly aware of parallel process—how clinicians' own shame and overcompensation can subtly mirror the experiences of the clients they are trying to help. I have felt both the harm of performance-based expectations and the repair of being met with attuned, shame-informed mentorship. These experiences have deepened my understanding of how supervision itself can be a site of shame reinforcement or relational healing—depending on how safety, flexibility, and neurodivergence are held.

This reflection has led me to a central question in this project: how can I serve my clients ethically without abandoning myself in the process? I have come to understand that maintaining a connection to myself is not in conflict with ethical care—it is part of it. I come to this project with a growing awareness that ethical care must include care for the self—and that sustainable, affirming practice requires an ongoing relationship with one's own history, needs, and complexity. This stance is supported by scholars such as Mogendorff (2013) and Mullan (2023), who critique dominant models of professionalism and academic writing that conflate ethical practice with neutrality, detachment, or self-erasure. These frameworks can lead therapists to suppress the relational, affective, and political dimensions of their work in service of appearing "objective." For me, reclaiming self-connection in clinical work is not a departure from ethical practice—it is an ethical stance in itself.

My social location has shaped both my access to support and my ability to reframe these experiences. As a white, university-educated woman, I have benefited from systemic privilege even when struggling within it. I had access to educational opportunities, safe therapeutic relationships, and the financial resources to pursue assessment and counselling. These supports

are not equitably available to everyone, and I carry awareness of how colonisation, ableism, and structural injustice continue to shape who is seen, understood, and supported in therapeutic and academic contexts. Mullan (2023) reminds us that decolonising therapy requires more than personal awareness—it requires an active interrogation of the systems we participate in, including how our own positionality shapes clinical practice.

I also recognise that the diagnostic frameworks I now find helpful exist within medicalised systems that have historically excluded or pathologised difference. Diagnoses like ADHD can be validating, but they can also inadvertently reinforce shame and stigma when framed in deficit terms. This tension is echoed by Mogendorff (2013), who highlights the challenges of integrating experiential knowledge into scholarly contexts that often privilege objectivity over lived truth.

I write through the lens of ADHD because that is the name I have been given—the one that finally helped make sense of years of overcompensating, crashing, masking, and trying to keep up. It is not the whole story. The shame I name has roots that stretch beyond executive dysfunction and lives in the quiet adaptations I have made in relationships, in the weight of unspoken legacies, and in the ways, I learned to disappear or perform. Some of what I carry may trace back to trauma, which is often intertwined with neurodivergence. Other aspects may point to overlapping forms of neurodivergence, reflecting the complexity I hold— and that many other neurodiverse individuals hold, too. This project is not an attempt to simplify or label, but to begin somewhere. ADHD gives me a way in—a language to speak about shame and survival—even as I continue to hold space for the pieces that don't fit neatly.

My current work as an intern therapist focuses largely on supporting neurodiverse children and youth, many of whom struggle with the same feelings of being "too much" or "not

enough" that I once carried. I have come to understand the power of relational spaces that invite authenticity and self-connection. This insight informs my intention to co-create therapeutic environments where clients feel safe enough to unmask and reflect without shame. This stance is supported by work from Kroll et al. (2024) and Bowers and Widdowson (2023), who emphasise the healing potential of identity-affirming therapeutic relationships for neurodivergent individuals.

I am especially attentive to how shame manifests in the therapy room—and how the clinician's response can either reinforce or interrupt internalised narratives of failure. Bernstein (2015), Conway (2019), and Sugarman (2019) each explore the complexity of working with ADHD clients from psychoanalytic perspectives, where countertransference and therapist emotional responses can both hinder and illuminate the work. Their reflections affirmed my own sense that the therapeutic frame itself must remain flexible and compassionate, particularly when shame is in the room.

Throughout this project, I have engaged in ongoing reflexivity. One form this has taken is the creation of a zine titled *Enough: A Zine to Metabolise Shame*, a creative and personal reflection on the themes explored in this capstone, which evolved alongside the very themes I was grappling within my writing process. It has been a way I have made sense of things that are hard to find the words for, and honours diverse ways of knowing, communicating, and experiencing the world. The zine blends narrative, poetry, and marginalia to hold the nonlinear, emotional, and embodied aspects of my inquiry. It emerged from a desire to integrate rather than compartmentalise my identities—and to challenge academic norms that privilege cognitive knowing over lived experience. Creating the zine has helped me metabolise shame, cultivate self-compassion, and deepen my awareness of what I bring into the therapy room.

Informed by the work of Neff (2023) and Galili-Weinstock et al. (2020), I have also recognised that self-compassion is central to our therapeutic practice—for clients and clinicians alike. Shame thrives in isolation and rigidity. Compassion opens a space for movement and curiosity.

In line with Mogendorff's (2013) critique, I have made intentional choices about what to disclose and what to withhold. I have sought to write from a place of authenticity without placing the burden of explanation on my family, my clients, or my younger self. This project does not centre my story but rather speaks to how stories like mine are shaped—and reshaped—within therapeutic relationships. It also reflects my inquiry into how lived experience can be used ethically and skilfully in clinical practice—not as self-disclosure for its own sake, but as a way to foster insight, self-curiosity, and a sense of shared humanity among clinicians—especially those who carry the quiet burden of needing to have it all figured out.

I approach this capstone as an act of reclamation and contribution. It is an attempt to translate pain into insight and walk with curiosity toward more connected, compassionate forms of practice. As I move forward in my work, I remain committed to neuroaffirming, relational, and anti-oppressive approaches that centre dignity and flexibility, and I hope this is reflected in what follows.

Definition of Terms

ADHD (Attention Deficit Hyperactivity Disorder)

A neurodevelopmental condition characterized by persistent patterns of inattention, hyperactivity, and impulsivity. ADHD significantly impacts executive functions including working memory, emotional regulation, and self-control, contributing to daily functional challenges (Barkley, 1997; Barkley, 2021; Williams et al., 2023).

Burnout

A psychological syndrome emerging from prolonged emotional exhaustion, depersonalization, and reduced personal accomplishment, frequently experienced by individuals with ADHD who consistently mask symptoms or over-function to meet societal expectations (Brattberg, 2006; Nyström et al., 2020).

Deficit-Based Language

Language emphasizing inadequacies, dysfunctions, or shortcomings, frequently employed in clinical or educational contexts, unintentionally reinforcing shame, negative self-concept, and self-criticism among individuals with ADHD (Iudici, 2014; Safren et al., 2005; Chapman & Botha, 2022).

Executive Dysfunction

Impairments in cognitive processes required for goal-directed behavior, including working memory, inhibition, emotional regulation, and planning, central to ADHD and frequently misinterpreted as moral failures or character deficits (Barkley, 1997; Kofler et al., 2017).

Masking

A coping strategy involving deliberate or unconscious attempts by neurodivergent individuals to conceal traits or behaviors perceived as socially undesirable or stigmatized, commonly employed by those with ADHD to avoid shame, rejection, or negative evaluation (van der Putten et al., 2024; Bowers & Widdowson, 2023).

Neuroaffirming Therapy

A therapeutic approach explicitly affirming neurodiversity, validating neurodivergent traits, and reframing perceived deficits as differences rather than disorders. This model

emphasizes collaboration, accessibility, and the cultivation of positive identity in therapy, aiming to counteract shame and stigma (Chapman & Botha, 2022; Kroll et al., 2024; Bolton, 2023).

Over-adaptation

An excessive, energy-intensive coping mechanism where individuals with ADHD attempt to compensate for perceived deficiencies, often through perfectionism and masking, leading to chronic stress, emotional exhaustion, and eventual burnout (Nyström et al., 2020; Bowers & Widdowson, 2023).

Parallel Process

A phenomenon in psychotherapy and supervision where emotional and relational dynamics experienced by clients are mirrored by therapists, who in turn recreate these dynamics within supervision, potentially amplifying shame or reinforcing maladaptive patterns if unaddressed (Zetzer et al., 2020; Taylor et al., 2006).

Rejection Sensitivity Dysphoria (RSD)

An intense emotional response associated with ADHD characterized by extreme sensitivity to perceived rejection, criticism, or failure, often resulting in overwhelming shame, anxiety, and interpersonal difficulties (Ayduk & Gyurak, 2008; Gao et al., 2017; Beaton et al., 2022).

Shame

A deeply distressing emotional experience rooted in the belief of fundamental personal inadequacy, often exacerbated in individuals with ADHD due to chronic invalidation, criticism, and social stigma. Shame differs from guilt by focusing on the self rather than specific actions (Brown, 2006; Goffnett et al., 2020).

Self-Compassion

An emotional stance characterized by kindness toward oneself, recognition of shared human experiences, and mindful awareness of distressing emotions, considered essential in mitigating shame, fostering emotional resilience, and promoting healthier coping among individuals with ADHD (Beaton et al., 2022; Neff, 2023; Galili-Weinstock et al., 2020).

Outline of the Capstone Project Chapters

This capstone is organized into three chapters that build upon one another to explore how shame shapes the lived experience of ADHD, how it shows up in therapeutic and supervisory dynamics, and how practitioners can support healing without reinforcing over-adaptation.

Chapter 2 critically reviews the existing literature at the intersection of ADHD and shame. It begins by identifying core psychological and relational mechanisms that contribute to shame in ADHD, including executive dysfunction, chronic invalidation, rejection sensitivity, and the impact of late or missed diagnosis. The chapter then explores how shame shapes coping strategies such as masking, perfectionism, and over-functioning—strategies that often result in burnout. A third section turns to the clinical implications of these patterns, examining how therapeutic and supervisory relationships can reinforce or disrupt shame through deficit-focused language, masking in the therapy room, countertransference, and parallel process. The final section considers pathways to healing, highlighting barriers to self-compassion and outlining interventions that support authentic expression, identity affirmation, and emotional sustainability in ADHD-focused therapy.

Chapter 3 synthesizes findings from the literature review and applies them to clinical and supervisory contexts. Drawing on both theory and lived experience, it explores how therapists and supervisors can recognize and interrupt shame dynamics—both in their clients and within themselves. This chapter offers practical recommendations for fostering attuned, neuroaffirming,

and shame-sensitive practices that resist burnout and support sustainable therapeutic engagement. It also reflects on the broader systemic and cultural forces that shape how neurodivergence is experienced and treated, and how therapists can respond with humility, creativity, and care.

Chapter 2: Literature Review

Shame is a pervasive yet underacknowledged emotional experience for individuals with ADHD, profoundly shaping self-perception, coping strategies, and therapeutic engagement. While shame has been widely studied in psychological literature—particularly in relation to trauma, identity, and emotional regulation—its specific role in the lived experience of ADHD in therapeutic contexts has received comparatively less empirical attention. This is especially true in therapeutic contexts, where shame is often present but rarely addressed directly within treatment models focused on symptom management or executive functioning.

This literature review explores the complex interplay between ADHD and shame through four interconnected themes. It begins with the core psychological mechanisms through which shame develops: executive dysfunction misread as moral failure, chronic invalidation, rejection sensitivity, and the emotional impact of late diagnosis. It then turns to coping strategies that often emerge in response to shame such as masking, perfectionism, and over-functioning. These strategies may offer protection in the short term but often lead to burnout and reinforce shame over time.

The third section turns to the therapeutic and supervisory dynamics that shape how shame is reinforced or disrupted in clinical spaces. Drawing on research related to parallel process and countertransference, this section explores how therapists' unconscious responses can mirror clients' earlier experiences of invalidation—but also how reflective, neuroaffirming practice can interrupt these patterns and foster healing. Finally, the review explores barriers and pathways to self-compassion— an essential, though often difficult, aspect of healing for individuals who have internalized shame as truth.

Together, these themes explore how shame emerges and persists in the context of the ADHD experience—and how therapy, when approached with attunement and reflexivity, can support more compassionate, sustainable shifts in identity and coping. Through this deeper understanding, this literature review aims to foster more nuanced and relationally informed approaches to therapeutic practice and supervision. Understanding how shame operates in parallel process dynamics within both therapy and supervision supports not only individual healing, but also the development of more ethical, attuned, and neuroaffirming systems of care (Zetzer et al., 2020, Taylor et al., 2006, Brown, 2006; Galili-Weinstock et al., 2020; Kroll et al., 2024).

Core Mechanisms of Shame in ADHD

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental condition characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning or development (American Psychiatric Association, 2022). Common societal understandings often reduce ADHD to stereotypes of distractedness or hyperactive children, frequently overlooking the deeper emotional and relational dimensions of the disorder (Barkley, 1997; Bernstein, 2015; Bowers & Widdowson, 2023). These misconceptions can minimize the severity of experiences for those living with ADHD, contributing significantly to misdiagnoses, inappropriate interventions, and a persistent feeling of being misunderstood, which frequently compounds into shame over time (Beaton et al., 2022; Kofler et al., 2017).

Although shame is not explicitly listed in the diagnostic criteria in the DSM-5-TR, its presence profoundly shapes the lived experiences of individuals with ADHD. Rather than arising from isolated incidents, shame in ADHD often emerges from an accumulation of misunderstandings and invalidations experienced throughout one's life (Nijmeijer et al., 2008;

Beaton et al., 2022). Cultural ideals around productivity, self-discipline, and behavioural conformity frequently clash with ADHD-related challenges such as executive dysfunction, emotional intensity, and rejection sensitivity, reinforcing narratives of inadequacy, moral failure, and internalized stigma (Barkley, 2021; Shaw et al., 2014; Uekermann et al., 2010; Soler-Gutiérrez, et al., 2023).

While the experience of shame is universal and especially common among individuals with ADHD, it is shaped by intersecting factors such as gender, race, upbringing and access to diagnosis. These differences are explored further in the final section of this theme.

Addressing shame requires a clear understanding of how it develops and persists in ADHD. This section explores four core mechanisms that contribute to shame, as identified in the literature: (1) executive dysfunction as moral failure, (2) chronic invalidation and misunderstanding, (3) rejection sensitivity and emotional intensity, and (4) the impact of late diagnosis and systemic messaging. Each shows how neurobiological differences collide with dominant social expectations, shaping self-perception, identity, and coping. Together they offer a foundation for therapeutic approaches that respond not just to symptoms, but to the shame embedded in lived experiences.

Executive Dysfunction as Moral Failure

Executive dysfunction is a hallmark of ADHD, but it remains poorly understood outside clinical contexts (Barkley, 1997; Kofler et al., 2017). Executive functions—including working memory, inhibition, planning, and emotional regulation—are essential for goal-directed behaviour (Barkley, 2021). Impairments in these areas can severely disrupt everyday tasks, such as starting or finishing projects or managing time and emotions, often resulting in repeated experiences of perceived or actual failure (Kofler et al., 2017).

Despite solid neurocognitive evidence, these challenges are frequently invisible, leading to misinterpretations of laziness, defiance, or apathy (Barkley, 1997; Karalunas et al., 2021). Such misunderstandings foster internal narratives of moral inadequacy, with individuals commonly internalizing beliefs like, "I must be broken," or "I just need to try harder" (Whitman, 2019, p. 73).

Karalunas et al. (2021) empirically illustrate this dynamic, showing that inattentive symptoms in youth predict negative self-perceptions of effectiveness, while hyperactivity and impulsivity correlate with diminished self-esteem and increased interpersonal difficulties. While shame is not specifically mentioned, this research underlines how executive dysfunction directly shapes self-concept and identity.

Whitman's (2019) psychoanalytic case study of a college student illustrates this experience well. Initially interpreted as laziness, the student’s academic procrastination was revealed through therapy as a defense mechanism—a strategy to shield himself from overwhelming shame. His therapeutic progress hinged on creating a relational space that dissociated personal worth from academic performance. This client had several co-morbidities, complicating distinctions between developmental challenges, ADHD, and other factors. Nonetheless, the case resonates deeply with experiences common in academic and therapeutic settings. While caution should be taken generalizing from single case studies, it offers valuable insights into the lived experience of shame intertwined with ADHD.

Kofler et al. (2017) reinforce this by linking working memory deficits to chronic disorganization, contributing significantly to internalized shame. Sugarman (2019) cautions against rigid therapeutic models that overlook these inherent developmental limitations, warning they may unintentionally intensify clients' shame.

Addressing executive dysfunction effectively requires therapeutic approaches that move beyond behavioural interventions to consider the relational and emotional dimensions that may block progress. Clinicians must understand these struggles as legitimate neurodevelopmental differences warranting compassion and targeted support, rather than a lack of care.

Chronic Invalidation and Misunderstanding

Executive dysfunction lays the groundwork for internalized shame, but it is often the repeated experiences of invalidation—both interpersonal and systemic—that truly embed and sustain these feelings. Daily interactions can frequently become sites of misunderstanding for neurodivergent folks, where emotional expressions, behavioural patterns, and cognitive rhythms are consistently met with frustration, criticism, or dismissal. Over time, these ruptures turn into internal narratives of inadequacy and shame (Whitman, 2019).

Qualitative research by Beaton, Sirois, and Milne (2022) highlights how misunderstanding ADHD symptoms often leads to intensified criticism and profound feelings of worthlessness. Participants described both overt criticisms and subtle invalidations such as dismissive gestures or unfavourable comparisons to neurotypical standards. Importantly, their findings underscore the buffering role of supportive, empathetic relationships in mitigating shame.

Bowers and Widdowson (2023) similarly identify how cumulative misunderstandings shape internalized shame among those with ADHD. They stress that behavioural interventions alone, without relational attunement, risk reinforcing shame through therapeutic parallel processes. Therapists must deeply understand neurodivergence and their own biases to avoid unintentionally perpetuating shame.

Turville's (2024) qualitative work highlights the emotional burden placed on neurodivergent individuals who must educate therapists working from neurotypical frameworks, reinforcing systemic gaps and personal inadequacy. Barkley (2021) echoes these insights, emphasizing that misunderstandings in therapeutic spaces directly heighten frustration and shame.

Collectively, this research underscores the necessity for therapy to move beyond behavioural modification towards relationally and emotionally attuned approaches. Therapists must actively cultivate affirming spaces, demonstrate genuine empathy, and foster corrective emotional experiences. Bowers and Widdowson (2023) emphasize that shame must be addressed through embodied compassion and genuine relational attunement, highlighting the critical role of clinician reflexivity to avoid replicating invalidating dynamics.

Rejection Sensitivity and Emotional Intensity

Like shame, rejection sensitivity (RS) is not an official diagnostic feature, but is a frequent experience of individuals with ADHD. Characterized by heightened emotional response to perceived social rejection or criticism, RS is deeply linked to both emotional dysregulation and interpersonal struggles that are typically heightened by and rooted in shame. Ayduk and Gyurak's (2008) Cognitive-Affective Processing System (CAPS) model explains that individuals high in RS anticipate rejection, triggering intense emotional responses and maladaptive coping behaviours.

Research consistently highlights this connection. Gao et al. (2017) found strong correlations between RS and mental health challenges such as depression, anxiety, loneliness, and social withdrawal, which frequently affect individuals with ADHD. Beaton et al. (2022) provide qualitative insights reinforcing this, noting pronounced reactions to criticism among

individuals with ADHD, potentially intensifying cycles of shame. Shaw et al. (2014) similarly underscore emotion dysregulation as a core feature of ADHD, rather than merely an associated trait.

Nijmeijer et al. (2008) illustrate how ADHD-related deficits in social cognition and emotional regulation exacerbate peer rejection and isolation, significantly contributing to persistent shame. Bora and Pantelis (2016) suggest these social cognition deficits not only heighten vulnerability to rejection but also indicate potential areas for targeted therapeutic intervention.

Mazzone et al. (2013) and Karalunas et al. (2021) add that repeated negative feedback and hyperactivity-impulsivity exacerbate interpersonal struggles and increase vulnerability to rejection and shame. Soler-Gutiérrez et al. (2023) identify common maladaptive strategies such as suppression and avoidance among individuals with ADHD, reinforcing negative self-perceptions and deepening experiences of shame.

Rejection sensitivity emerges as both a risk factor and an intervention opportunity. Recognizing and addressing how RS leads to emotional distress and shame can inform therapeutic approaches that foster resilience and social connectedness, breaking entrenched shame-based patterns in individuals with ADHD.

Late Diagnosis and Systemic Messaging

The increasing visibility of ADHD in adults—particularly among women and gender-diverse individuals—has led to a rise in late-in-life diagnoses. While diagnosis can offer affirmation, clarity, and validation, it also frequently brings along with it a certain level of emotional complexity. Diagnosis is rarely a neutral event; it reframes one's narrative, illuminating old wounds, missed opportunities, and deeply internalized narratives of failure.

Shame, in this context, is multi-layered: it stems not only from lived experiences but from what individuals internalized about themselves in the absence of accurate understanding and support (Beaton et al., 2022; Whitman, 2019).

Huynh et al. (2024) found that adults diagnosed later in life—particularly women—report significantly higher depression, anxiety, and emotional distress. This suggests the profound emotional costs of unrecognized ADHD, which can lead individuals to internalize lifelong challenges as personal inadequacies. Beaton et al. (2022) similarly describe diagnosis as both a relief and a rupture, validating lived experiences but simultaneously uncovering grief, regret, and anger over years spent masking, overcompensating, or doubting oneself. For many, these adaptive strategies—especially when developed in high-performance or compliance-driven environments—become deeply embedded, creating external appearances of success while reinforcing narratives of shame and inadequacy (Huynh et al., 2024).

Once again, Whitman's (2019) case study highlights this dynamic well: where a late ADHD diagnosis prompted the client to re-examine deeply entrenched beliefs of personal failure, which lead to both cognitive reframing, but also a process of grieving. This shows that diagnosis can be a narrative rupture with significant implications on both identity and emotion.

Iudici (2014) cautions against overly medicalized interpretations that may unintentionally reinforce negative self-concepts, perpetuating a cycle of self-stigmatization. At the same time, adopting a neurodivergent-affirming framework is important, as it positions ADHD as a legitimate neurodevelopmental difference rather than a personal failing or moral inadequacy. From this perspective, ADHD diagnosis becomes a lens through which to build self-compassion, access community, advocate for accommodations, and reclaim personal agency, rather than a pathology or problem (Soler-Gutiérrez et al., 2023).

Of course, intersectional factors further complicate the landscape of late diagnosis. Women and gender-diverse individuals often experience delayed diagnosis due to high levels of internalizing behaviors and socially conditioned masking (Beaton et al., 2022). Social expectations of emotional composure and social competence mean that these individuals may mask more intensely or be dismissed more easily, leading to quieter and more deeply internalised forms of shame (Beaton et al., 2022; Mullan, 2023). BIPOC individuals encounter additional barriers, including systemic racism and diagnostic biases, resulting in chronic underdiagnosis or misdiagnosis shame (Beaton et al., 2022; Mullan, 2023). This marginalization further compounds shame, as the absence of accurate understanding leads to the interpretation of personal failure rather than systemic neglect (Mullan, 2023).

Shame, in these cases, becomes not only internalized but inherited, shaped by environments that prize conformity, high performance, or obedience over authentic expression. What looks like success on the outside may sometimes reflect a form of self-suppression (Bowers & Widdowson, 2023). Upbringing and environmental context can influence the expression of symptoms, contributing to delays in accurate diagnosis and support (Beaton et al., 2022; Huynh et al., 2024; Luo et al., 2019).

Clinically, therapists working from a neuro-affirming stance must recognize that an ADHD diagnosis represents both a loss and a reclamation: grieving the past while opening new possibilities for self-understanding. Effective therapeutic approaches, therefore, do not seek to "fix" the symptoms of ADHD, but rather to facilitate narrative repair and identity reconstruction, while offering collaborative scaffolding as needed. Therapists and supervisors can support clients and supervisees by creating spaces where they feel safe to express complex emotions without fear of judgment or invalidation (Bowers & Widdowson, 2023). Embracing the tension between

acknowledging genuine struggle and affirming neurodivergent identity can transform diagnostic experiences from reinforcing shame to fostering meaningful self-understanding, acceptance, and empowerment (Chapman & Botha, 2022; Kroll et al., 2024).

Coping and the Risk of Over-Adaptation

For many individuals with ADHD, coping strategies emerge not from conscious choice but from a deep-seated need to minimize rejection, navigate misunderstanding, or pre-empt punitive responses. These strategies are shaped by systemic context, presentation of symptoms, and the severity it is experienced. For example, the ability to mask or blend in can be temporarily protective, but is not universally accessible (van der Putten et al., 2024). For those whose symptoms are pronounced or whose identities intersect with marginalized statuses related to race, class, gender, or disability, the possibility of concealment may never have existed. In these contexts, coping may manifest distinctly as withdrawal, defiance, shutdown, or expressive emotional dysregulation (Sugarman, 2019)—each equally protective, yet frequently misunderstood. Whether the response is to disappear, overperform, or to protest, these strategies share a common origin in shame.

This theme explores the complexities and nuances of shame-related coping mechanisms within ADHD, critically examining the subtle yet significant line between genuine therapeutic progress and harmful over-adaptation. The following subthemes delve deeper into how masking and camouflaging, perfectionism, procrastination, avoidance, and the risks of over-functioning and burnout interplay within therapeutic contexts. Each subtheme highlights the necessity of creating therapeutic spaces that support authentic self-expression, counteract shame, and foster sustainability and self-acceptance.

Masking and Camouflaging

Although masking has received substantial attention in autism research, its manifestation in ADHD remains comparatively under-explored, despite growing qualitative and empirical evidence that many individuals with ADHD engage in camouflaging behaviors driven by stigma avoidance, social acceptance, and rejection prevention (van der Putten et al., 2024; Beaton et al., 2022). Masking in ADHD manifests in a variety of ways—from perfectionistic overcompensation, suppression of emotional intensity, to conscious mimicry of neurotypical behavioural norms. While superficially adaptive, these behaviours frequently impose significant emotional costs, intensifying shame, identity confusion, and leading to cycles of burnout so familiar to those who hold an ADHD diagnosis (Bowers & Widdowson, 2023; van der Putten et al., 2024).

Beaton et al. (2022) found that adults with ADHD reported engaging in masking primarily as a protective response to repeated invalidation and social threat, shaping themselves into more "acceptable" versions—less impulsive, less emotional, more productive—to mitigate rejection or misunderstanding. Although effective for immediate social acceptance, participants described substantial exhaustion and the underlying sense of not being acceptable to others. These findings resonate with broader research on rejection sensitivity in ADHD, highlighting that individuals with heightened emotional vigilance are prone to intense self-monitoring and editing in interpersonal interactions (Bowers & Widdowson, 2023).

Van der Putten et al. (2024) empirically strengthens this narrative, providing quantitative evidence that camouflaging behaviours among adults with ADHD significantly correlate with heightened exhaustion, negative self-perception, and increased mental health challenges. Their findings underscore the essential therapeutic task of supporting authentic self-expression to reduce reliance on energetically costly adaptive strategies. However, Turville (2024) emphasizes

that many neurodiverse individuals describe masking within therapy sessions, highlighting a paradox wherein therapy intended for healing can inadvertently reinforce masking behaviors if therapeutic approaches remain overly aligned with neurotypical expectations.

Chapman and Botha (2022) argue that traditional therapy frameworks often implicitly endorse masking behaviours by emphasizing external behaviour modification over genuine self-expression. Similarly, Mikami et al. (2017) critique conventional social skills training, pointing out its inadvertent reinforcement of superficial behavioral conformity rather than fostering authentic relational skills. Faraone (2021) also underscores this complexity, criticizing interventions overly focused on symptom alleviation without considering the adaptive functions that masking behaviours may serve for individuals navigating stigmatizing environments. This concept will be explored further under theme three where we consider therapeutic dynamics.

Overall, the consequences of masking extend significantly into identity formation and mental health outcomes. Nyström et al. (2020) illustrate through qualitative exploration that older adults with ADHD frequently reach points of emotional collapse after lifelong camouflaging. These adaptive strategies initially enable social functionality but may eventually culminate in burnout, exhaustion, and fragmented self-perceptions.

Despite clear qualitative and emerging quantitative support, masking in ADHD remains insufficiently studied relative to autism, with little research addressing intersectional dynamics, such as how cultural, racial, or gendered factors shape masking behaviours. Notably, the experiences of BIPOC and gender-diverse individuals with ADHD are underrepresented, highlighting a significant research gap (Beaton et al., 2022). This gap obscures understanding of how intersecting marginalizations amplify the necessity, intensity, and psychological toll of masking behaviours, highlight a need for further focused investigation.

Recognizing masking as a coping mechanism driven by chronic invalidation and systemic stigma shifts the therapeutic narrative away from symptom alleviation toward fostering environments that affirm authentic self-expression. Therapists are thus challenged to critically evaluate therapeutic frameworks that may inadvertently perpetuate masking, advocating instead for approaches rooted in empathetic attunement, relational authenticity, and sustainable self-acceptance.

Perfectionism, Procrastination, and Avoidance

Perfectionism, procrastination, and avoidance may initially seem contradictory—one characterized by relentless striving, the others by delay or withdrawal. Within the lived experience of ADHD, however, these strategies are deeply interwoven with coping, driven by internalized shame and fear of exposure. Far from being indicators of laziness or apathy, they often represent adaptive turned maladaptive responses cultivated in environments where difference is penalized and conformity rewarded (Conway, 2019; Sugarman, 2019).

Perfectionism frequently manifests in individuals with ADHD, especially those who have internalized the belief that their acceptance hinges on how they perform in the world. For many, the pursuit of perfection is less about success and more about avoiding criticism or perceived failure that can feel so deeply painful, effectively serving as emotional armour against exposure and judgment (Beaton et al.,2022). Once again, Whitman's (2019) case study illustrates this: in which the client's outward achievements as a student in Engineering masked deep-seated emotional distress, perpetuating a destructive cycle of over-functioning and internal emotional turmoil.

Procrastination, while seemingly opposite to perfectionism, often emerges from the same shame-driven roots. Barkley (1997) provides a theoretical framework, identifying executive

function deficits—particularly difficulties with task initiation, planning, and sustained attention—as fundamental to ADHD-related procrastination. When these executive impairments intersect with the heightened stakes imposed by perfectionism, the result is frequently task paralysis. Whitman (2019) clarifies that procrastination in ADHD contexts often reflects not avoidance of responsibility but an intense fear of failing or being perceived as inadequate.

Sugarman (2019) explicitly identifies avoidance as a maladaptive coping mechanism closely tied to developmental struggles and shame in individuals with ADHD. Such avoidance behaviours are protective, aimed at mitigating emotional pain by circumventing potentially humiliating situations. However, they ultimately tend to reinforce shame by creating a cycle of unmet expectations and perceived personal failures.

These coping strategies are especially pronounced among late-diagnosed adults. Beaton et al. (2022) note that many adults diagnosed later in life have deeply internalized that their worth depends upon continuous overcompensation. This belief drives relentless efforts to appear competent, which often masks intense anxiety, guilt, or despair (Bowers & Widdowson, 2023).

Therapeutic interventions can inadvertently exacerbate these issues if they disproportionately emphasize productivity, goal attainment, or behavioural accountability without addressing the underlying emotional vulnerabilities and executive dysfunctions that fuel these coping strategies (Bowers & Widdowson, 2023). Instead, Whitman (2019) argues for a therapeutic space where individuals can safely explore and understand the underlying fears driving their perfectionism and avoidance, in order to gradually shift towards accepting imperfection, vulnerability, and growth mindset.

Despite their clinical relevance, research specifically addressing perfectionism, procrastination, and avoidance within ADHD contexts remains sparse. While these phenomena

are extensively studied independently, few studies thoroughly investigate their interconnectedness and their specific relationship to shame and identity in ADHD. Additionally, intersectional factors such as gender, race, and socioeconomic status are rarely considered in existing literature, despite evidence suggesting their significant influence on how these coping behaviours manifest (Huynh et al., 2024).

This calls for therapeutic approaches that carefully integrate emotional and relational support alongside executive functioning strategies that are necessary within our systemic context (Bowers & Widdowson, 2023; Whitman, 2019). Cognitive-behavioural methods, while helpful for addressing specific behaviours, might fall short without concurrently addressing underlying shame and emotional wounds (Chapman & Botha, 2022; Kroll et al., 2024). Therapeutic practices must therefore emphasize validation and compassion, reframing perfectionism, procrastination, and avoidance not as moral weaknesses but as understandable adaptations shaped by invalidating experiences (Sugarman, 2019). Viewing these coping mechanisms through the lens of shame-informed practice fosters empathy and nuanced intervention.

Over-Functioning, Burnout, and Emotional Collapse

For many individuals with ADHD over-functioning emerges as a deeply ingrained response to being seen simultaneously as "too much" and "not enough": excessively emotional, too scattered, insufficiently organized, yet perpetually pressured to fit in. In pursuit of validation, individuals with ADHD often find themselves in cycles of constant doing—working harder, trying longer, producing more—as if their very worth depends on this continual proof of competence. Beneath this often lies the internalized belief that slowing down, or simply existing without performance, risks exposure and inevitable rejection.

Nyström et al. (2020) illustrate these dynamics through their qualitative exploration of older adults diagnosed with ADHD. Participants recounted a lifetime of masking and intensive compensatory strategies to appear "normal". Their sustained over-functioning frequently culminated in burnout, emotional collapse, or significant life disruptions, such as job losses or relationship breakdowns, often triggering their late-in-life ADHD diagnoses. Beyond the visible consequences, participants described feeling unseen, emotionally disconnected from themselves, and silently exhausted from the relentless pressure to keep up appearances.

Supporting this narrative, Brattberg (2006) identifies a significant overlap between undiagnosed ADHD, PTSD and chronic conditions like burnout and long-term sick leave. Brattberg also highlights the pervasive yet under-recognized emotional and somatic burdens associated with managing untreated ADHD. Individuals, often misunderstood by clinicians and peers alike, become vulnerable to chronic stress, emotional depletion, and even trauma-like responses. The study urges healthcare providers to recognize ADHD not merely as a behavioural disorder but as a critical factor in understanding chronic emotional exhaustion and burnout.

Jones et al. (2024) qualitative study looking at neurodivergent clients' experiences in therapy extend this discussion, highlighting how neurodivergent burnout is frequently misdiagnosed as depression. This misrecognition often leads therapists to prescribe interventions emphasizing productivity or behavioural activation, inadvertently deepening the underlying emotional distress. Once again, the authors advocate for therapeutic frameworks that explicitly validate neurodivergent experiences, actively reduce cognitive and emotional demands, and prioritize resilience-building over behavioural conformity. Without this shift, therapy itself risks becoming another stage on which individuals feel compelled to perform.

Linked to these findings, Sáez-Francàs et al. (2012) reveal the high prevalence of ADHD among individuals with chronic fatigue syndrome, noting how ADHD can significantly amplify symptoms of fatigue, anxiety, depression, and even suicidality. Though shame was not explicitly mentioned, the emotional costs described resonate strongly with the cumulative impact of sustaining lifelong compensatory coping strategies like over-functioning.

The transition from chronic over-functioning to burnout rarely occurs abruptly; it is more typically the endpoint of prolonged hypervigilance, emotional suppression, and psychological depletion. This trajectory is deeply intertwined with identity and self-worth, where slowing down can feel akin to admitting personal failure. While many clients have adapted to high-pressure environments by performing competence at great personal cost, therapists must be mindful not to inadvertently uphold these dynamics. Without intentional reframing, the therapy space itself can become another arena for performance. Instead, it must be cultivated as a safe, validating environment that not only acknowledges the lived realities of performance-based survival, but also offers a relational experience of authenticity, permission, and emotional vulnerability (Bowers & Widdowson, 2023).

Recognizing over-functioning and burnout through a shame-informed, neuroaffirmative lens calls for a fundamental shift in clinical understanding. These coping strategies are not failures of resilience, but rather protective adaptations forged in response to environments that perpetually demand proof of competence while providing little acknowledgment of struggle. Therapeutic interventions, therefore, should focus on helping clients learn to rest without guilt, set realistic expectations, and internalize their inherent worth independent of productivity. Much of this relies on a felt sense of safety within the therapeutic space, and the slow development of self-compassionate lenses and self-understanding.

Navigating Shame Dynamics for ADHD Individuals in Therapy and Supervision

Therapists and supervisors are not immune to shame dynamics—particularly in work with ADHD, where many find themselves navigating both professional and personal neurodivergent identities. Therapeutic spaces can at times become a mirror reflecting the broader societal invalidation clients with ADHD routinely encounter. This mirroring process is known in the literature as "parallel process", describing the unconscious transfer of emotional and relational patterns from therapy to supervision and vice versa (Zetzer et al., 2020).

This section explores four critical subthemes: (1) deficit-focused language and productivity bias, (2) masking behaviors in therapeutic interactions, (3) parallel process and countertransference, and (4) supervision as a potential site of shame or a space for healing. Together these subthemes illustrate how shame in ADHD therapy is not only internal to the client, but often relationally co-constructed. Awareness of these patterns may allow clinicians to respond with greater reflexivity and authenticity, reducing unintentional reinforcement of shame.

Deficit-Focused Language and Productivity Bias

Therapeutic spaces often reinforce normative ideals of productivity and functionality, unintentionally suggesting that neurodivergent individuals—such as those with ADHD—are fundamentally deficient or inadequate (Chapman & Botha, 2022). This deficit-focused approach arises from traditional therapy models that prioritize symptom reduction, behavioural conformity, and normalization, rather than validating diverse cognitive and emotional experiences (Hume, 2022; Chapman & Botha, 2022; Bolton, 2023). As a result, executive dysfunction and emotional intensity in ADHD can be mistakenly portrayed as moral failings rather than recognized as genuine neurological differences, fueling cycles of internalized shame (Chapman & Botha, 2022; Hume, 2022; Turville, 2024). These frameworks often reflect implicit

assumptions about what is ‘functional’ or ‘productive,’ reinforcing shame by positioning neurodiverse experiences as deficient (Chapman & Botha, 2022).

Chapman and Botha (2022) challenge the widespread harm caused by deficit-oriented therapeutic approaches, calling for a shift toward neurodiversity-informed practice. They argue that traditional frameworks often overlook the adaptive purposes behind behaviours seen as problematic or maladaptive, increasing clients' feelings of shame and invalidation. Faraone (2021) echoes this perspective, noting that clinical practices often focus too heavily on behaviour reduction without adequately appreciating or validating the adaptive strategies used by individuals with ADHD. This approach inadvertently deepens feelings of internalized stigma and shame.

Iudici (2014) highlights how diagnostic labels, when applied without careful consideration, can reinforce stigma and narratives of defectiveness, reducing personal agency. Such labelling intensifies negative self-perceptions, exacerbating feelings of inadequacy and isolation that hinder therapeutic progress.

Similarly, Turville (2024), through qualitative exploration, gives voice to neurodivergent clients who frequently feel misunderstood when therapists interpret executive dysfunction from rigid, neurotypical viewpoints. Although derived from a master's thesis and not peer-reviewed, these insights align closely with broader scholarly critiques (Bowers & Widdowson, 2023; Jones et al., 2024). They underscore how misattunement in therapy can cause significant relational ruptures by failing to recognize adaptive coping strategies as anything other than avoidance or defiance.

At the same time, it is important to acknowledge the genuine challenges many neurodivergent individuals experience within their systemic contexts (Williams et al., 2023).

While embracing a strengths-based approach is essential, it would be overly simplistic—and ultimately inaccurate—to deny the real struggles and disadvantages associated with neurodivergence. For example, Kofler et al. (2017) highlight that executive dysfunction, such as working memory deficits, can lead to substantial difficulties in organization and daily functioning that can lead to significant consequences and distressing experiences that compound shame. These real-world impairments need meaningful acknowledgment and therapeutic support.

Luo et al. (2019) emphasize the diversity and complexity inherent in ADHD experiences, detailing varied clinical presentations, developmental trajectories, and responses to treatments. This heterogeneity means that experiences of shame and coping mechanisms among individuals with ADHD can differ widely, necessitating personalized and contextually sensitive therapeutic approaches.

Williams et al. (2024) provide empirical evidence that many clients feel dissatisfied with therapies perceived as overly rigid and productivity focused. Clients frequently reported feeling misunderstood when therapeutic practices emphasized symptom reduction without addressing deeper emotional and relational needs. These findings highlight the importance of therapy approaches that affirm neurodivergent identities, prioritize emotional validation, and focus on relational attunement rather than rigid productivity standards.

Traditional Cognitive Behavioural Therapy (CBT) methods, such as those described by Safren et al. (2005), although commonly used and helpful in symptom management, may inadvertently reinforce normative biases by emphasizing behavioural conformity. These methods can neglect the deeper relational and emotional contexts, unintentionally increasing shame in

clients whose experiences differ significantly from normative expectations (Williams et al., 2024).

To effectively address these issues, there must be an intentional shift from pathologizing frameworks toward affirming, neurodiversity-informed therapeutic practices (Chapman & Botha, 2022; Bolton, 2023). This shift involves actively reshaping therapeutic language and interventions to acknowledge neurodiverse experiences and coping strategies, thereby reducing shame and supporting authentic therapeutic engagement. Future research should explore how incorporating neurodivergent-affirming strategies into therapeutic practice can reduce client experiences of shame, improve therapeutic outcomes, and simultaneously acknowledge and address the real systemic challenges neurodivergent individuals face.

Masking in the Therapy Room

As previously explored in the section on masking as coping, masking—the conscious or unconscious attempt to conceal or minimize one's neurodivergent traits—is prevalent among individuals with ADHD due to broader societal pressures to appear neurotypical (Beaton, Sirois, & Milne, 2022). Within therapeutic spaces specifically, masking carries heightened stakes, as clients strive to maintain connection by being “good”—compliant, emotionally regulated, and productive—to avoid therapist judgment and further invalidation (Bowers & Widdowson, 2023). Although this form of masking can be temporarily protective, it naturally reinforces internalized shame, leading to emotional exhaustion, and disconnecting individuals from their authentic identities (Hume, 2022; Chapman & Botha, 2022).

Empirical support from van der Putten et al. (2024) highlights significant mental health costs associated with masking behaviours among adults with ADHD, such as increased anxiety, depression, and emotional fatigue. Their findings underscore the importance for clinicians to

understand masking not simply as avoidance or resistance, but as a taxing adaptive strategy that emerges from chronic experiences of stigma and misunderstanding (van der Putten et al., 2024).

In therapeutic practice, Bowers and Widdowson (2023) emphasize the necessity of creating environments that actively encourage neurodivergent clients to reduce masking and safely explore vulnerability. Traditional therapeutic frameworks, often prioritizing normative functionality, can unintentionally perpetuate masking behaviors, negatively impacting the therapeutic relationship and exacerbating client shame. This perspective is reinforced by qualitative insights from Turville (2024), whose participants reported feeling pressured to educate therapists or conform to neurotypical standards, significantly intensifying feelings of isolation and emotional distress in therapy.

Lewis (2024) further highlights the challenges therapists diagnosed with ADHD encounter around masking, especially in therapeutic settings. Therapists struggle with the balance between maintaining professional boundaries and authentically integrating their ADHD traits into practice, which impacts their emotional boundaries, therapeutic congruence, and self-disclosure. Such experiences offer valuable insights into the nuanced dynamics of masking behaviours for both therapists and clients in therapeutic relationships.

The tension within therapeutic practice arises from the need to balance promoting reduced masking for authenticity while recognizing masking as a legitimate coping strategy in less accommodating environments outside therapy. Chapman and Botha (2022) critically examine how conventional therapeutic models often implicitly endorse masking by treating neurodivergent traits as deficits to be managed rather than expressions of neurological diversity to be affirmed. Mikami et al. (2017) similarly highlight how interventions like social skills

training may inadvertently reinforce masking through rigid conformity rather than authentic social engagement.

Addressing masking effectively in therapy requires creating explicit spaces where authenticity and vulnerability are valued above normative performance, and that extends to what the therapist models in session. Clinicians must critically reflect on their implicit biases and actively affirm neurodivergent identities to foster genuine self-expression and therapeutic growth (Bowers & Widdowson, 2023; van der Putten et al., 2024). Future research should develop and evaluate therapeutic strategies specifically targeting masking behaviors, particularly among intersectionally marginalized ADHD populations, to ensure therapeutic interventions actively support authentic identity exploration so necessary to addressing shame.

Parallel Process and Countertransference

Creating therapeutic environments capable of addressing deep-seated shame and masking behaviours requires careful attention to the dynamics of parallel process and countertransference within therapy and supervision contexts. Parallel process refers to the phenomenon where relational and emotional dynamics occurring in the therapist-client relationship are unconsciously mirrored within the supervisor-therapist relationship (Taylor et al., 2006; Zetzer et al., 2020). Although parallel process provides valuable insights, it remains somewhat controversial due to limited empirical validation and varying interpretations among clinicians (Taylor et al., 2006). Nevertheless, when thoughtfully integrated alongside empirically supported therapeutic strategies, it can significantly enrich therapeutic and supervisory practice.

Recognizing parallel processes is particularly relevant for therapists working with ADHD clients, given the shared experiences of emotional intensity, misunderstanding, and frustration that often occur (Chapman & Botha, 2022). Zetzer et al. (2020) identified how therapists'

emotional reactions—such as frustration, helplessness, or feeling overwhelmed—often mirror clients' experiences of shame and inadequacy. These emotional parallels, if unacknowledged, can unintentionally reinforce cycles of shame. Supervisors who inadvertently embody productivity biases or normative expectations can replicate invalidating dynamics experienced by clients outside therapy, intensifying therapist shame (Taylor et al., 2006; Zetzer et al., 2020).

Countertransference—the emotional reactions of therapists towards clients, influenced by their own histories or emotional states—plays a pivotal role within these dynamics (Bernstein, 2015; Conway, 2019). Bernstein (2015) emphasizes that therapists working with ADHD clients are particularly susceptible to countertransference confusion, stemming from cognitive deficits interwoven with deeper intrapsychic conflicts. Misinterpreting clients' ADHD symptoms as resistance or defiance can exacerbate internalized shame, reinforcing clients' feelings of being misunderstood or inherently flawed. Bernstein advocates for therapists to integrate awareness of cognitive limitations with psychoanalytic insights into intrapsychic conflicts, viewing countertransference as a valuable source of insight into early relational experiences and a guide for therapeutic adjustments.

Lewis (2024) provides further depth, investigating how person-centered counsellors diagnosed with ADHD navigate therapeutic congruence and authenticity within their practice. Lewis's qualitative findings highlight how deficit-oriented narratives in therapy training and practice pose challenges for neurodivergent practitioners, forcing them to manage authenticity, impulsivity, and emotional boundaries carefully. Counsellors in Lewis's study expressed concerns about rigidity and the inaccessibility of traditional therapeutic expectations, suggesting that their ADHD experiences provide unique insights, enhancing empathy and connection but also creating risks related to emotional boundaries and self-disclosure.

Conway (2019) emphasizes therapist attunement, advocating for the constructive use of uncomfortable countertransference reactions within the therapeutic relationship. While Sugarman (2019) underscores the necessity of emotional regulation for therapists, it is equally crucial to acknowledge that overly regulated therapeutic environments may inadvertently reinforce unrealistic norms of emotional stability, potentially heightening shame for ADHD clients. Genuine attunement, inclusive of authenticity and emotional "messiness," can offer relatable and healing experiences for clients dealing with ADHD-related shame. Furthermore, it is important to recognize that concepts such as countertransference may themselves reflect neurotypical biases, potentially limiting their relevance or usefulness for neurodivergent therapists and clients.

Effectively leveraging parallel process and countertransference requires therapists and supervisors to cultivate self-awareness, openly acknowledge shared struggles, and maintain reflective practices about their emotional reactions to clients. Authentic attunement, rather than rigid emotional regulation, can foster therapeutic environments that genuinely validate neurodivergent experiences and promote meaningful healing (Bernstein, 2015; Zetzer et al., 2020; Lewis, 2024). Future research should explore additional strategies for therapists and supervisors to constructively navigate these dynamics, especially within diverse and intersectionally marginalized ADHD populations, as a way to enhance therapeutic outcomes and reducing cycles of shame.

Supervision as a Shame Site or Healing Space

Given the complexity of working with shame-based dynamics related to neurodivergence, supervision occupies a pivotal space within the therapeutic landscape, capable of profoundly influencing therapists' experiences of shame and growth, particularly for new

therapists such as myself. Much like therapy itself, supervision does not exist in isolation but mirrors broader societal and relational dynamics. Taylor et al. (2006) describe supervision as a context where parallel processes frequently unfold, with therapists and supervisors unconsciously mirroring the emotional patterns and struggles present in the therapy room. For therapists working with neurodivergent clients, these dynamics can become particularly pronounced, amplifying experiences of frustration, misunderstanding, or shame (Zetzer et al., 2020).

When supervision unintentionally replicates normative expectations—such as rigid standards of productivity, compliance, and emotional control—it also has the potential to reinforce therapists' feelings of inadequacy and shame. Zetzer et al. (2020) illustrate how supervisors' frustrations or critical attitudes towards therapists can inadvertently echo the dismissive or invalidating experiences clients face outside the therapy context. Lewis (2024) further supports this point by highlighting how deficit-oriented narratives within supervision and training can pose significant challenges, especially for neurodivergent practitioners who struggle with rigid therapeutic expectations, authenticity, and emotional boundaries. Such misattunement can lead therapists to internalize a narrative of deficiency, perpetuating cycles of shame not only within themselves but potentially within their therapeutic relationships.

However, supervision also holds immense potential as a healing space, one capable of fostering growth, resilience, and authentic self-expression (Chapman & Botha, 2022). Supervision that embraces epistemic humility—acknowledging the complexity and variability of neurodivergent experiences—can provide critical validation and support for therapists navigating their own internalized shame and countertransference reactions (Taylor et al., 2006; Zetzer et al., 2020). Lewis's (2024) research underscores how supervisors who value therapists' unique

neurodivergent insights can significantly enhance empathy, connection, and therapeutic congruence. By normalizing the inevitability of therapeutic ruptures and repairs, supervisors create a relationally safe environment, enabling therapists to explore their vulnerabilities without fear of judgment (Conway, 2019).

Importantly, supervision that encourages authenticity and reflexivity is essential. Conway (2019) emphasizes that effective supervision involves tolerating and constructively engaging with negative countertransference and challenging emotional experiences. Rather than insisting on stringent emotional regulation—which can sometimes reinforce unrealistic norms of emotional stability—supervisors are encouraged to model genuine attunement, embracing a degree of relational "messiness." This authenticity can be profoundly therapeutic, particularly for therapists and clients who have experienced invalidation linked to their neurodivergence (Sugarman, 2019).

When dealing with complex relational matters, the supervisory space becomes most effective when supervisors explicitly acknowledge and critically reflect on parallel processes, encouraging therapists to develop deeper self-awareness and self-compassion. By doing so, supervision shifts from a potential site of shame reinforcement to a powerful context for healing, growth, inquiry, and sustainable therapeutic practice.

Understanding and navigating these therapeutic dynamics requires clinicians to acknowledge their potential contributions to clients' shame experiences without fear or excessive caution, and normalizing our own imperfection and humanity can be an important step towards healing. By embracing authenticity, normalizing rupture and repair, and prioritizing reflexivity, therapists and supervisors actively cultivate therapeutic environments emphasizing compassion,

validation, and genuine human connection. This approach promotes healing and reduces risks of burnout and over-adaptation inherent in traditional, deficit-focused models.

The Journey Towards Self-Compassion: Barriers and Pathways

If shame is a powerful force shaping how individuals with ADHD see themselves and cope with challenges, then self-compassion is a much-needed pathway forward. Yet, for many individuals with ADHD, self-compassion is not easily accessed. Low self-compassion has been linked to poorer mental health outcomes (Beaton et al., 2022), and fear of vulnerability or perceived unworthiness often makes compassionate responses feel threatening rather than soothing (Steindl et al., 2023).

Therapists may unintentionally reinforce this dynamic when therapy spaces centre normative expectations, rely too heavily on validation without addressing core beliefs, or fail to affirm neurodivergent identity. At the same time, research points to promising therapeutic pathways—such as pairing relational authenticity, creative expression, and identity-affirming care with some directive interventions—that can help shift shame-based coping and support the development of a self-compassionate identity.

The following section will further explores both barriers that make self-compassion feel unsafe or inaccessible, and the pathways that may support clients and therapists with ADHD move towards self-acceptance, emotional resilience, and healing.

Barriers: Compassion as Threat and Therapy as Exposure

One major barrier individuals with ADHD face when trying to develop self-compassion is the feeling that compassion itself is threatening. Compassion, especially when coming from others, can feel unsafe or undeserved, leading to resistance, defensiveness, and even mistrust towards those offering kindness. Steindl et al. (2023) note that therapists working with

compassion-focused therapy (CFT) often see this resistance clearly: clients can interpret compassion as confirmation of their inadequacies, feeling those compassionate responses stem from pity rather than genuine care. For therapists, this requires a careful balance—they need to express empathy and validation without unintentionally suggesting fragility or failure.

However, overly cautious approaches can also backfire. Therapists who become too careful, trying desperately to avoid triggering negative feelings, risk creating relationships that feel artificial or inauthentic. Genuine connection, honest communication, and openness from the therapist are crucial for successfully addressing the complex emotions surrounding shame and vulnerability. Therapists and supervisors must also remain aware of their own biases and beliefs about ADHD and compassion, ensuring these don't unintentionally shape therapy in harmful ways. These challenges are often shaped by deeper social and clinical contexts that frame vulnerability and neurodivergence as unsafe or as a weakness.

Barriers to developing self-compassion often come from internalized social stigma and even from certain therapy practices. Brown's Shame Resilience Theory (2006) highlights that facing shame directly, through vulnerability and genuine connection, can transform internal stigma into resilience. But for many people with ADHD, barriers such as believing productivity equals worth, fearing vulnerability, and navigating a history of criticism and misunderstanding can stand in the way of developing self-compassion. Often, the fear of vulnerability is not irrational—it reflects lived experiences where openness led to rejection or shame, making emotional self-protection feel necessary (Steindl et al., 2023; Kroll et al., 2024). These dynamics align closely with broader neurodiverse experiences of internalised failure, social isolatation, and hypersensitivity to criticism (Nijmeijer et al., 2008; Whitman, 2019).

Compounding this issue, therapy itself can sometimes feel more like exposure than healing for people with ADHD. Traditional therapeutic approaches often rely on deficit-focused language, productivity biases, and implicit expectations of neurotypical functioning. This can create an environment where individuals feel compelled to mask their neurodivergent traits (Hume, 2022). Driven by a deep-seated fear of judgement or rejection, clients may hide their genuine selves, inadvertently turning therapy into yet another context where shame-based coping gets reinforced (Hume, 2022; Bowers & Widdowson, 2023).

Galili-Weinstock et al. (2020) also caution that therapies grounded solely in common factors like warmth and passive validation, without explicitly addressing deeply entrenched negative beliefs about the self, can paradoxically intensify feelings of inadequacy. They suggest that carefully tailored directive interventions—those that directly challenge negative self-perceptions—might be necessary before warmth and validation can genuinely be received as affirming rather than reinforcing inadequacy.

Understanding the function of these barriers helps reframe resistance as self-preservation rather than pathology. Resistance to self-compassion is not merely an obstacle, but an adaptive defense. Steindl et al. (2023) describe resistance as a protective strategy developed to guard against further emotional injury, criticism, or vulnerability. Therapists must therefore acknowledge and validate these defenses, reframing them not as stubbornness or reluctance but as intelligent responses to past harm. By honouring these protective functions, therapists can foster a safer therapeutic space, gradually guiding clients towards greater openness, vulnerability, and ultimately, genuine self-compassion.

Pathways: Fostering Self-Compassion, Connection and Creative Integration

Navigating beyond the barriers of shame and self-criticism common in individuals with ADHD requires therapeutic approaches that are both affirming and practical. Therapeutic pathways towards healing and self-compassion are diverse, often leveraging relational depth, creative expression, and carefully structured interventions that honour neurodiversity. Beaton et al. (2022) highlight self-compassion as a key therapeutic goal, showing that individuals with ADHD typically have lower levels of self-compassion, which directly links to poorer mental health outcomes. Their quantitative analysis underscores self-compassion as essential for emotional resilience and well-being. In related qualitative research, Beaton et al. (2022) emphasize therapeutic environments that actively nurture self-compassion through validation and reducing criticism.

Brown (2006) emphasizes the profound importance of "speaking shame" within empathetically attuned relationships as a foundational step towards transforming deeply internalized shame. This relational process provides a corrective emotional experience, countering chronic invalidation by reinforcing a narrative of inherent worthiness, acceptance, and belonging (Whitman, 2019). Similarly, Hume (2022) underscores the therapeutic value of explicit authenticity and transparency from therapists, tailored to accommodate neurodivergent needs. Such relational authenticity not only validates experiences often misunderstood or pathologized but actively constructs therapeutic safety, fostering deeper emotional exploration and resilience.

Lewis (2024) further enriches this perspective by exploring how person-centered counsellors diagnosed with ADHD navigate therapeutic congruence and manage authenticity within their practice. Lewis highlights how deficit-focused narratives within training and practice environments can exacerbate shame, advocating for a more integrative approach that

acknowledges and leverages ADHD traits as strengths. This aligns closely with Hume's emphasis on authenticity and relational safety, suggesting that therapist congruence and self-awareness significantly enhance empathy, connection, and therapeutic effectiveness.

Therapeutically, pathways to self-compassion involve clear interventions that blend empathy with active skill-building. Neff's (2023) extensive work demonstrates the effectiveness of self-compassion practices, such as compassionate letter-writing and mindfulness techniques, to challenge negative self-talk common among individuals with ADHD. Similarly, Kroll et al. (2024) promote therapy spaces that explicitly affirm neurodivergent identities, encouraging acceptance rather than assimilation or masking—an essential step toward genuine self-compassion.

Therapists' direct interventions can also powerfully facilitate pathways toward self-compassion. Galili-Weinstock et al. (2020) provide empirical evidence supporting directive interventions characteristic of cognitive behavioural therapies, as effective means to challenge ingrained patterns of self-criticism and promote kinder self-perceptions. However, this approach must be sensitively balanced; overly rigid application risks alienating ADHD clients, who often experience structured interventions as overwhelming or invalidating if their neurodiversity is inadequately acknowledged (Williams et al., 2024).

To address these concerns, Steindl et al. (2023) propose a nuanced combination of psychoeducation, collaborative formulation, and experiential techniques such as chairwork and guided imagery, methods especially suited to ADHD populations who often benefit from dynamic, multisensory therapeutic strategies. These techniques facilitate an embodied experience of compassion, directly countering the abstract and cognitive traps of self-criticism. Similarly, Neff (2023) outlines explicit components of Mindful Self-Compassion (MSC) and Compassion-

Focused Therapy (CFT), which cultivate compassion through experiential practice and therapist modeling—essential pathways for clients accustomed to internalized criticism and self-doubt.

Identity-affirming care emerges as a particularly crucial pathway. Research by Kroll et al. (2024) highlights the transformative power of explicitly validating neurodivergent identities within therapeutic relationships. By actively acknowledging and accommodating sensory sensitivities, executive function differences, and emotional intensities common in ADHD, therapists foster an affirming therapeutic space. This approach profoundly shifts clients' self-perceptions, reducing internalized shame and enhancing self-acceptance (Chapman & Botha, 2022). Notably, these identity-affirming interventions significantly improve therapeutic outcomes even in the absence of formal diagnoses, underscoring relational validation itself as a fundamental healing mechanism.

Creative, neuroaffirming approaches represent another critical therapeutic pathway often overlooked in traditional frameworks. Therapeutic practices integrating art, play, and narrative methods not only align well with the strengths of many individuals with ADHD but also provide unique avenues for metabolizing shame (Positionality Reflection). Creative processes externalize and concretize internal struggles, transforming abstract feelings of inadequacy into tangible expressions that can be observed, shared, and reshaped within safe therapeutic relationships. These approaches can powerfully reinforce narratives of competence, self-efficacy, and identity resilience (Whitman, 2019). Girard-Joyal and Gauthier (2022) specifically highlight the creative strengths evident in adults with combined ADHD presentation (ADHD-C), emphasizing that impulsivity and hyperactivity significantly enhance divergent thinking and creative expression. This supports neuroaffirming and strengths-based therapeutic approaches by reframing traditionally stigmatized traits as valuable sources of creativity and resilience.

Finally, structured yet flexible therapeutic scaffolding remains essential (Barkley, 2021; Mikami et al., 2017). Effective therapeutic relationships for ADHD-related shame carefully balance clear, actionable strategies with sufficient flexibility to adapt to individual client needs and pacing. The therapist's role in modeling adaptive coping strategies, openly acknowledging personal limitations, and engaging transparently in mutual problem-solving can significantly reinforce a more compassionate and self-affirming internal dialogue in clients.

In synthesis, therapeutic pathways addressing ADHD-related shame most effectively weave together relational authenticity, directive but flexible interventions, identity-affirming validation, and creative neuroaffirming approaches. Together, these elements not only challenge but actively transform internalized narratives of inadequacy, fostering a sustainable self-compassionate identity.

Summary

This literature review explored the emotional structure of ADHD-related shame, tracing how it emerges, takes root, and is often reinforced—sometimes subtly, sometimes systemically—across developmental, relational, and therapeutic contexts. From a synthesis of current research related to ADHD, shame, and clinical practice, four interwoven themes emerged: the core mechanisms of shame, the coping strategies shaped in response, the clinical dynamics that can replicate or disrupt shame, and the therapeutic conditions that support healing. While many of these elements—executive dysfunction, rejection sensitivity, masking, and emotional exhaustion—have been explored in isolation, few works examine how they converge through the lens of shame and become mirrored within therapeutic and supervisory relationships.

For individuals with ADHD, shame often emerges through an accumulation of misattunements—where executive dysfunction is interpreted as moral failure, emotional intensity

as immaturity, and masking becomes a necessary survival strategy. These experiences shape not only internal narratives but also relational patterns, particularly when shame is met with invisibility or pressure to perform. In response, individuals often develop coping strategies—such as over-functioning, perfectionism, or emotional withdrawal—that are frequently praised but ultimately unsustainable.

Clinically, these dynamics are often mirrored. Therapists and supervisors, especially when navigating their own neurodivergence or internalized expectations, may unknowingly recreate the very shame-based dynamics clients bring into the room. Parallel process and countertransference offer critical—but underutilized—entry points for reflection and rupture repair. When left unexamined, these patterns can quietly reinforce the very experiences clients are working to heal.

At the same time, the literature points to concrete and hopeful pathways. Self-compassion, relational safety, identity-affirming practice, and creative interventions can shift shame from a static identity into something more fluid—something that recognises strength, invites authenticity, and allows clients to soften under the gaze of care. These interventions may help clients metabolize shame that has long served as a protective strategy. Still, these pathways are not always accessible—particularly when compassion is experienced as exposure or when therapeutic norms subtly reinforce productivity or compliance over authenticity.

While the research offers compelling directions, notable gaps remain: shame is rarely centred as a primary lens in ADHD literature; clinician dynamics are often decontextualized; and supervision is underexplored as a potential site of harm, healing, or reflexivity.

Chapter 3 will build on these insights by exploring how therapists and supervisors can recognize, disrupt, and transform shame dynamics—supporting not only their clients but also

themselves in the process. In doing so, it asks: What would it look like to practise in a way that is not just neuro-affirming, but shame-literate, relationally attuned, and sustainable for both clients and therapists alike?

Chapter 3: Discussion and Application

The purpose of this capstone was to explore how shame shaped coping mechanisms and identity in individuals with ADHD, and how therapy and supervision either disrupted or reinforced these patterns. It integrated academic research, clinical perspectives, and lived experience to highlight the emotional and relational aspects of ADHD often overlooked by traditional interventions. The project aimed to support counsellors, supervisors, and emerging clinicians—particularly those working with or identifying as neurodivergent—by promoting relational, shame-sensitive, and neurodivergent-affirming therapeutic practices.

Discussion of Findings

This section synthesizes key insights from the literature review through the lens of clinical application and supervisory dynamics. It highlights how core mechanisms of shame in ADHD—including chronic invalidation, executive function misinterpretation, and masking—manifest not only in therapeutic settings but also in supervision. Drawing from Chapter 2, three interrelated findings are particularly salient: shame dynamics are mirrored in supervision through parallel process; masking and over-adaptation extend into the supervisory space; and dominant models of professionalism may obscure the relational conditions necessary for working through shame. These findings underscore the need to reimagine supervision not only as a space for skill development but also as a container for emotional integration, identity affirmation, and the ethical development of neurodivergent clinicians.

Shame as Parallel Process

The concept of parallel process illustrates how the emotional and relational dynamics experienced by clients with ADHD—feelings of inadequacy, overwhelm, or misattunement—can be unconsciously replicated within the supervisory relationship. This mirroring offers both

risk and opportunity. When supervisors operate from normative expectations or deficit-based frameworks, they may inadvertently reinforce the very shame that supervisees are working to metabolise in their client work (Taylor et al., 2006; Zetzer et al., 2020).

These dynamics are especially salient for emerging therapists navigating their own neurodivergence. As Lewis (2024) notes, neurodivergent supervisees often mask or over-function in supervision to conform to implicit norms of competence. These strategies are shaped by earlier experiences of misattunement and survival and may be misread as avoidance or lack of insight if not held within a relational and neuroaffirming frame. Supervision that embraces epistemic humility—honouring multiple ways of knowing and processing—can serve as a space for transformation to occur. Supporting supervisees in metabolising shame within the supervisory relationship is not only reparative—it also enables them to do ethical and attuned work with clients, particularly those navigating similar dynamics.

Masking and Over-Adaptation Beyond the Therapy Room

Masking and over-adaptation—coping mechanisms rooted in shame—are not confined to therapy. As explored in Chapter 2, clients with ADHD often conceal their traits to avoid judgment or rejection (van der Putten et al., 2024; Beaton et al., 2022). This dynamic is mirrored in supervision. Emerging therapists may feel pressure to perform, suppress emotion, or downplay differences in processing, learning, or communication in order to appear competent.

This mutual masking—by both therapist and supervisor—not only mirrors earlier relational trauma, but also limits opportunities for mutual growth. When authenticity is sacrificed, the supervisory relationship may replicate the very dynamics of invalidation it seeks to address. As Bowers and Widdowson (2023) emphasise, true healing requires spaces where masking can be acknowledged and unlearned. Supervision that welcomes nonlinear processing,

emotional vulnerability, and moments of rupture and repair offers a corrective relational experience (Zetzer et al., 2020; Steindl et al., 2023). When these dynamics are named and worked through collaboratively, the supervisory space becomes a site of reflective practice, not only enhancing clinician well-being but also modelling the therapeutic stance needed to support clients engaged in similar patterns of over-adaptation.

Challenging the Constraints of Traditional Professionalism

Dominant narratives of professionalism often prioritise neutrality, composure, and behavioural control—traits that may reinforce shame in therapists whose identities or ways of being fall outside these norms (Mogendorff, 2013; Mullan, 2023). For neurodivergent clinicians, these expectations can feel stifling or exclusionary. Executive function variability, emotional intensity, or alternative communication styles are frequently misinterpreted as incompetence or pathology.

Misinterpretations like this risk reinforcing internalised shame and driving further masking. As Bolton (2023) and Chapman and Botha (2022) argue, decentring neuronormativity is essential for creating inclusive, identity-affirming supervisory relationships. Supervisors who equate competence with emotional neutrality may inadvertently reinforce perfectionism and over-functioning in their supervisees and subsequently their clients—amplifying the risk of burnout, eroding opportunities for authentic growth, and reinforcing shame narratives.

When professionalism is associated with emotional restraint or rigid composure, it may undermine the supervisory alliance itself. Supervisees may hesitate to bring forward uncertainty, self-doubt, or shame-based experiences for fear of appearing inadequate. This dynamic limits the supervisor’s ability to attune to the supervisee's internal world and may compromise trust-building, and reflective engagement—all of which are necessary conditions for ethical and

sustainable practice. Supervision that overemphasises performance or composure risks replicating the same dynamics of invisibility and suppression that many neurodivergent clients face in therapeutic and educational systems.

Instead, supervision grounded in attunement, reflexivity, and relational courage allows clinicians to show up more fully. As Kroll et al. (2024) note, identity-affirming therapeutic relationships are foundational for sustainable, self-compassionate practice. When supervisors model authenticity and emotional transparency, they help supervisees metabolise shame and move toward integration rather than performance. This not only reduces the risk of burnout but also empowers clinicians to work in ways that are both relationally responsible and personally sustainable.

Gaps in the Literature

While the reviewed literature provides valuable insight into the emotional experiences of ADHD and the relational functions of supervision, several notable gaps were noted. Shame, while frequently present, is rarely centred directly in empirical ADHD research. It often emerges beneath the surface of adjacent constructs—rejection sensitivity, emotional dysregulation, or low self-compassion—rather than being examined as a relational and systemically embedded experience (Beaton et al., 2022; Sugarman, 2019; Goffnett et al., 2020).

The supervision literature, similarly, tends to overlook how shame, masking, and countertransference unfold within neurodivergent supervisory dyads. While parallel process has been explored in psychodynamic contexts where shame emerges (Taylor et al., 2006; Zetzer et al., 2020), it is rarely applied to therapists with ADHD or understood through the lens of neurodivergence, where shame is often potent. Lewis (2024) offers important early insight, yet

broader inquiry into how supervision can either reinforce or interrupt shame cycles remains lacking.

Intersectionality is another critical gap. Many existing studies reflect dominant narratives that overlook how ADHD and shame are shaped by race, gender, class, and other structural factors. Huynh et al. (2024) and Mullan (2023) underscore the specific harm faced by marginalised individuals whose identities intersect with systemic bias and diagnostic delay. Iudici (2014) similarly critiques how diagnostic labels can unintentionally reinforce deficiency narratives rather than promote agency or identity integration.

Finally, models of therapist development often reflect narrow assumptions about growth—equating it with composure, emotional regulation, normative behaviour, or productivity. These ideals are grounded in neuronormative and ableist values and may exclude supervisees who process differently (Bolton, 2023). If the self of the therapist is not welcome, what will be communicated to the client? Much of what is framed as "self-of-therapist" work continues to lean toward identifying and fixing perceived deficits, rather than cultivating reflexivity, self-compassion, building on strengths or developing a coherent professional identity rooted in authenticity and relational safety.

These gaps shape who feels seen, supported, and safe in supervisory relationships—and who continues to feel the need to mask. This, of course, is cultural. However, too often in Canadian and American contexts are new clinicians encouraged to take their emotional experiences "to their own therapy," positioning their distress as an individual issue to be managed elsewhere. While therapy is a valuable support, this approach overlooks the rich opportunities for learning, integration, and transformation that can only emerge within supervision itself. By relocating emotional and identity work outside the supervisory space,

clinical training risks reinforcing shame, masking, and over-functioning at precisely the stage where relational attunement is most needed. Addressing these dynamics in supervision is not a diversion from ethical practice—it is foundational to it. Creating supervision spaces that explicitly support identity integration, emotional safety, and relational accountability enables clinicians to do the same for their clients. To not do so is exclusionary of many individuals whose lived experiences are so important to the counselling field.

Applications

This final section applies the insights from the literature review and discussion to clinical supervision, exploring how shame, masking, and identity-based coping strategies can be either reinforced or gently dismantled within supervisory relationships. While previous chapters have outlined how individuals with ADHD often internalise shame through years of misattunement, invalidation, and productivity-based expectations, this section turns toward the supervisory space as a potential site for working through shame-based coping. Drawing from established relational, feminist, reflective, and narrative-informed supervision models, this application builds on existing approaches while integrating a neuroaffirming and shame-sensitive lens rooted in the lived experiences of ADHD.

As we have established in the previous section, clinicians navigating neurodivergence are often encouraged to compartmentalise their emotional experiences—to take their shame "to their own therapy"—rather than metabolise it within the supervisory space itself. Though personal therapy plays an important role, this framing risks reducing supervision to technical oversight and overlooking its relational, systemic, and ethical potential. When left unexamined, supervision may unintentionally replicate the very dynamics it seeks to counter, reinforcing masking, over-functioning, and emotional suppression. These patterns not only contribute to

overadaptation and burnout but may also be carried forward into client work. The following principles and practices aim to support supervisors in creating spaces where emotional authenticity, identity integration, and mutual reflection are not only welcomed but understood as essential to sustainable and ethical clinical work.

Grounding in Existing Supervisory Models

While shame-informed, neuroaffirming supervision remains an emerging area of practice, this project builds upon a constellation of established frameworks that centre reflexivity, relational safety, and systemic awareness. These supervisory approaches—while not originally developed with ADHD or neurodivergence in mind—offer fertile ground for reimagining supervision as a space where shame can be metabolised rather than reinforced.

Reflective supervision, particularly within the infant and early childhood mental health field, positions the supervisory relationship as a collaborative, emotionally attuned process that prioritises parallel process, mutual regulation, and relationship-based practice (Barron & Eaves, 2022). Supervision in this context is not reduced to technical correction or performance evaluation but instead becomes a space where both supervisor and supervisee explore the emotional weight of clinical work. This model aligns closely with the needs of neurodivergent clinicians, who may be navigating masking, internalised shame, and perfectionism in their clinical and supervisory relationships. However, as Barron and Eaves (2022) caution, reflective supervision is not always experienced as safe or helpful—particularly for supervisees from marginalised backgrounds—underscoring the importance of attending to power, identity, and relational safety.

Relational and intersubjective supervision models further deepen this understanding by conceptualising supervision as a co-created relational field in which power, emotion, and identity

are actively at play (Carroll, 2009). Rather than assuming a stance of expertise, relational supervisors work with epistemic humility—an orientation that is essential when supporting supervisees who experience shame and difference. These models emphasise the supervisor's role in attending to parallel process and countertransference, offering a foundation for the kind of shame-sensitive, emotionally attuned supervision this capstone advocates.

Feminist supervision models similarly disrupt hierarchical dynamics and highlight how supervision is shaped by social context. These frameworks urge supervisors to name systemic power, acknowledge their own positionality, and foster mutual accountability within the supervisory dyad (Brown, 2016). A feminist lens invites us to critique not only what happens in supervision, but how it is structured: who feels able to show up fully, whose emotions are welcome, and what ways of being are rewarded or pathologised. These questions are particularly salient for neurodivergent supervisees, who may have internalised the message that their traits—such as emotional intensity or executive variability—are liabilities rather than legitimate ways of engaging with the world.

Postmodern and narrative approaches offer another layer of integration. They encourage supervisors to support supervisees in deconstructing dominant discourses of competence and professionalism—especially those rooted in ableist and neuronormative ideals—and to co-author new, more liberatory narratives (Mitchell, 2022). Narrative-informed supervision invites reflection on the stories therapists tell themselves about what makes a "good therapist" or a "real professional"—stories that are often shaped by shame, perfectionism, and performance pressure. This framework, grounded in curiosity and identity exploration, offers supervisees a way to externalise self-criticism and re-author their professional identities in more compassionate, contextually grounded ways.

Finally, neurodivergent-affirming and anti-oppressive frameworks, such as those articulated by Bolton (2023) and Chapman and Botha (2022), provide a critical lens for identifying how dominant supervision practices may inadvertently reinforce shame. These scholars call for a shift away from deficit-based thinking and toward a supervision culture that affirms difference, challenges normative assumptions, and attends to the social realities shaping both client and clinician experience. Integrating this stance means recognising that supervision is not neutral. It is shaped by systemic forces—and has the potential to either replicate or transform them.

Rather than proposing an entirely new supervisory model, this capstone extends the principles of these frameworks through the specific lens of ADHD, shame, and over-adaptation. It highlights the ways in which neurodivergent clinicians—particularly those navigating late diagnosis or internalised deficit narratives—may experience supervision as a site of disconnection or invisibility, unless efforts are made to create spaces that explicitly welcome emotional honesty, process over performance, and identity integration. The sections that follow offer practical principles and strategies to support supervisors in holding such spaces.

Principles of Shame-Sensitive, Neuroaffirming Supervision

This section offers six guiding principles for creating supervisory relationships that are attentive to shame, affirming of neurodivergence, and responsive to systemic and relational dynamics. These principles draw from existing relational, feminist, reflective, and neuroaffirming frameworks, and are grounded in the findings of this capstone. Rather than offering a step-by-step protocol, they invite supervisors to consider how they might adapt their stance, language, and structure to better support clinicians—particularly those navigating ADHD

and histories of invalidation or over-adaptation—in developing sustainable, authentic clinical practice.

Reframe Supervision as Relational and Reparative

Shame-sensitive supervision positions the supervisory relationship as central—not peripheral—to professional development. Rather than treating supervision as a space for correction or performance oversight, this approach views it as a relational container for co-regulation, reflection, and repair. Supervisors who adopt a relational stance grounded in emotional attunement and epistemic humility can interrupt the internalised shame often carried by neurodivergent clinicians (Heffron & Murch, 2010; Carroll, 2009). For supervisees with ADHD, whose clinical formation may have been shaped by misattunement or productivity pressure, this orientation can offer a crucial space to metabolise shame and develop a more integrated professional identity (Brown, 2016).

Recognise and Gently Disrupt Masking and Over-Functioning

Masking and over-functioning—common coping mechanisms among neurodivergent individuals—often remain invisible in supervision. These patterns may emerge as perfectionism, emotional detachment, or hyper-compliance and are frequently misread as signs of competence or control. Bowers and Widdowson (2023) note that these behaviours often emerge from internalised shame and fear of rejection. Supervision that encourages gentle reflection can help identify where these patterns are active. Prompts such as “What feels difficult to name here?” or “What part of you is trying to get it right?” can open space for unmasking. Steindl et al. (2023) caution that compassion itself can feel unsafe for individuals with deeply embedded shame, and thus it is essential to approach these moments with patience and co-regulated care. Barron and

Eaves (2022) further underscore that safety in supervision must be co-constructed and critically aware of power and identity dynamics.

Model a More Expansive Understanding of Professionalism

Prevailing professionalism norms often equate clinical competence with emotional restraint, composure, and behavioural predictability. These expectations can marginalise clinicians whose relational style, affect regulation, or executive function diverge from these norms. Bolton (2023) argues for a redefinition of professionalism that decentrals neuronormative assumptions and legitimises diverse ways of being. Supervisors can support this shift by modelling flexibility, emotional presence, and reflective awareness of their own positionality. Chapman and Botha (2022) emphasise the need for therapeutic and supervisory relationships to challenge normalising frameworks and affirm lived neurodivergent experience. Feminist models of supervision similarly encourage attention to systemic and contextual influences on behaviour and identity, rather than interpreting difference through a deficit lens (Brown, 2016).

Integrate Emotional and Identity Work into Supervision

The emotional and identity dimensions of clinical work are often relegated to personal therapy, leaving supervision focused solely on skill and technique. For clinicians with ADHD, whose therapeutic development may be intertwined with navigating diagnostic identity and internalised shame, this division can feel artificial and invalidating. Mitchell (2022) proposes a narrative approach to supervision that supports ethical congruence and values-based integration through structured reflection and identity exploration. Supervisors can incorporate simple reflective practices—such as check-ins about self-concept, emotional labour, or moments of misalignment—to support ongoing integration. Metaphor, journaling, or embodied reflection can also help supervisees explore the intersections of identity, emotion, and therapeutic practice.

Supervise with Intersectionality and Positionality in Mind

Safety in supervision is shaped not only by the relational dynamic but also by the broader systems of power in which it is embedded. For neurodivergent clinicians who are also racialised, gender-diverse, disabled, or otherwise marginalised, the stakes of unmasking or vulnerability may be considerably higher. Barron and Eaves (2022) emphasise that reflective supervision is not equally experienced as safe, particularly when power and positionality remain unspoken. Supervisors must name their own social locations, explicitly address systemic inequities, and invite shared responsibility for shaping supervisory culture. Mullan (2023) argues that failing to interrogate the colonial and normative underpinnings of therapy risks perpetuating harm. Shame-sensitive supervision must therefore engage with both interpersonal and structural dimensions of safety, recognising that what feels supportive to one supervisee may feel exposing to another.

Support Narrative Re-Authoring and Identity Integration

Internalised shame is often sustained through unexamined narratives—stories about not being good enough, being too much, or not belonging. Supervision can become a space to examine and revise these stories. Mitchell (2022) suggests that narrative supervision practices, when used developmentally and reflexively, can support supervisees in externalising critical inner dialogues and exploring preferred ways of understanding their professional identity. Supervisors might ask, “What story are you telling yourself about this moment?” or “Whose voice do you hear when you doubt yourself?” These questions can help bring awareness to dominant discourses around competence and allow space for self-authored, values-aligned identities to emerge.

Implications for Training Programs and Supervisory Culture

The insights presented in this capstone carry clear implications for how clinical training and supervisory structures are designed, delivered, and evaluated. If supervision is to become a site of healing and integration rather than replication of shame-narratives, it is important to move beyond deficit-based, performance-driven models and embrace relationally attuned, shame-sensitive, growth-oriented and neuroaffirming approaches. This includes supporting neurodivergent supervisees and preparing supervisors to examine their own emotional responses, biases, and positioning within broader systems.

First, graduate counselling programs would do well to embed shame and neurodivergence as core components within both clinical and supervisory education. Shame is a pervasive, though often unspoken, force in therapeutic relationships—particularly for neurodivergent clinicians who have internalised narratives of deficiency through years of misattunement and institutional exclusion (Beaton et al., 2022; Bernstein, 2015; Bowers & Widdowson, 2023). Despite this, few models explicitly address how shame unfolds in supervisory relationships or how it can be metabolised through attuned, relational practice (Zetzer et al., 2020; Brown, 2016). Embedding shame literacy and neurodivergence-informed content into coursework would help future supervisors recognise, hold, and work through these complex dynamics.

Second, it is important for supervisors to not only be equipped to evaluate clinical skill but also to engage in reflective, relational, and narrative-informed practices. Too often, they are expected to assess without being supported in exploring their own countertransference, perfectionism, or assumptions about competence. As Mitchell (2022) and Carroll (2009) suggest, supervision is not a neutral act—it is relational, ethical, and shaped by systemic forces. Supervisors who lack the space to reflect on their own fears, identities, or emotional blind spots may unknowingly reinforce the very shame dynamics their supervisees are working to unlearn.

Programs should normalise peer consultation, supervision-of-supervision, and ongoing professional development grounded in identity-affirming and neurodiversity-informed principles.

Third, programs must resist equating growth with productivity, composure, or emotional restraint—traits that often reflect dominant cultural values rather than actual therapeutic readiness. Bolton (2023) and Chapman and Botha (2022) critique how professional cultures prioritise behavioural control over authenticity. For supervisees with ADHD, these assumptions can exacerbate internalised shame, particularly when executive variability or emotional intensity is viewed as incompetence. Educational environments that dismiss emotional process or require polished performance may lead neurodivergent clinicians to mask, limiting their access to relational repair and integration. Supervisory assessment must evolve to include reflexivity, relational attunement, and the ability to hold complexity—not just the performance of it.

Finally, these commitments must be reflected structurally, not just in theory. Evaluation tools, feedback frameworks, and supervision contracts should explicitly acknowledge relational process, emotional labour, and identity-based stress that may emerge in response to evaluative environments where there is a power differential. As Kroll et al. (2024) highlight, identity-affirming structures are not only ethical—they're clinically effective. When supervisees feel seen in their neurodivergence and supported in their complexity, they are more likely to practise sustainably, build meaningful client relationships, and remain engaged in the profession.

Training environments, like therapy and supervision, are relational ecosystems. When designed with shame literacy, neurodivergent identity, and systemic context in mind, they can become sites of transformation—for clinicians and the systems they serve. These changes will not come from rigid expectations or polished performance. Sustainability is not found in perfection, but in presence, and the acceptance of our own humanity as clinicians.

Conclusion

Supervision, like therapy, holds the potential to be either a place where shame is reinforced or transformed. When shaped by deficit-based norms, evaluative rigidity, or unexamined power dynamics, it can replicate the same conditions that have shaped internalised shame in both neurodiverse supervisees and their clients. But when approached relationally—with humility, attunement, and a willingness to name the systems we move within—supervision becomes a space where shame can be metabolised and identity no longer needs to be masked in service of appearing professional (Brown, 2006; Chapman & Botha, 2022; Zetzer et al., 2020).

As this capstone has shown, shame is not a side-effect of ADHD—it is often central to how it is experienced and understood. It is shaped by years of misattunement, invalidation, and cultural narratives that define competence through neurotypical ideals (Beaton et al., 2022; Bolton, 2023). These dynamics also show up in supervisory relationships, where clinicians may over-function, suppress uncertainty, or conform to implicit expectations rather than editing or concealing parts of themselves to fit a professional ideal. Attending to shame and supporting identity in supervision is not an optional or secondary task—it is essential. While this is particularly urgent for clinicians with ADHD and other forms of neurodivergence, shame is a near-universal human experience. Without relational space to process it, clinicians may carry forward patterns of masking and burnout that compromise both their own wellbeing and their work with clients.

This chapter has proposed a framework for supervision that is both shame-sensitive and neuroaffirming—rooted in literature, clinical experience, and lived insight. It is not offered as a fixed model, but as a call for more intentional application of relational and reflexive principles, especially with neurodivergent supervisees. It is also an invitation: to supervisors, educators, and

institutions to reflect on the professional cultures we uphold. What expectations do we reinforce? What traits are affirmed, and which ones are pathologised? And how might our supervisory relationships change when we make room for the full complexity of who supervisees are—without performance, and without shame?

As many of the scholars cited here remind us, healing is not found in polished technique or perfection. It emerges through presence, relational courage, and the slow, ongoing work of making it safe to be seen (Brown, 2006; Kroll et al., 2024). In supervision—as in therapy—what we attend to shapes what becomes possible. When we are willing to meet shame with care and curiosity, we create conditions where something else can emerge: connection, integration, and ways of practising that are not only effective, but sustainable.

References

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Association. https://doi/book/10.1176/appi.books.9780890425787

Ayduk, Ö., & Gyurak, A. (2008). Applying the cognitive-affective processing systems approach to conceptualizing rejection sensitivity. *Social and Personality Psychology Compass, 2*(5), 2016-2033. https://doi.org/10.1111/j.1751-9004.2008.00143.x

Barkley, R. A. (1997). Behavioral inhibition, sustained attention, and executive functions: Constructing a unifying theory of ADHD. *Psychological Bulletin, 121*(1), 65–94. https://doi.org/10.1037/0033-2909.121.1.65

Barkley, R. A. (2021). *Taking charge of adult ADHD* (2nd ed.). Guilford Press.

Barron, C. C., & Eaves, T. (2022). Introduction to a special section on the supervisee's perspective of reflective supervision/consultation. *Infant Mental Health Journal*, 43, 203 -206. https://doi.org/10.1002/imhj.21976

Beaton, D. M., Sirois, F. M., & Milne, E. (2022). The role of self-compassion in the mental health of adults with ADHD. *Journal of Clinical Psychology, 78*(12), 2490–2502. https://doi.org/10.1002/jclp.23354

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

Bernstein, E. (2015). When the analytic patient has attention deficit hyperactivity disorder. *Journal of the American Psychoanalytic Association, 63*(2), 275–302. https://doi.org/10.1177/0003065115581371

Bowers, C., & Widdowson, M. (2023). Transactional Analysis Psychotherapy with Clients who are Neurodivergent: Experiences and Practice Recommendations. *International Journal of Transactional Analysis Research*, *14*(1), 32–54. https://doi.org/10.29044/v14i1p32

Bolton, M. J. (2023, June 15). De-centering Neuronormativity is an Imperative in Humanistic Psychotherapy: Towards a Neurodiversity-Informed, Person-Centered Approach. https://doi.org/10.31234/osf.io/q2t8h

Bora, E., & Pantelis, C. (2016). Meta-analysis of social cognition in attention deficit/hyperactivity disorder (ADHD): comparison with healthy controls and autistic spectrum disorder. *Psychological Medicine*, *46*(4), 699–716. https://doi.org/10.1017/S0033291715002573

Brattberg, G. (2006). PTSD and ADHD: underlying factors in many cases of burnout. *Stress and Health, 22*(5), 305–313. https://doi.org/10.1002/smi.1112

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society, 87*(1), 43-52. https://doi.org/10.1606/1044-3894.3483

Brown, L. S. (2016). Supervision essentials for the feminist psychotherapy model of supervision. American Psychological Association. https://doi.org/10.1037/14878-000

Chapman, R., & Botha, M. (2022). Neurodivergence-informed therapy. *Developmental Medicine & Child Neurology, 65*(3), 310–317. https://doi.org/10.1111/dmcn.15384

Conway, F. (2019). Clinical challenges in the psychoanalytic treatment of ADHD patients: A commentary on Dr. Whitman's case presentation. *The Psychoanalytic Study of the Child*, *72*(1), 94–98. https://doi.org/10.1080/00797308.2019.1557478

Faraone, S. (2021). The World Federation of ADHD International Consensus Statement: 208 evidence-based conclusions about the disorder. *Neuroscience & Biobehavioral Reviews, 128*. (add page number) https://doi.org/10.1016/j.neubiorev.2021.01.022

Galili-Weinstock, L., Chen, R., Atzil-Slonim, D., Rafaeli, E., & Peri, T. (2020). Enhancement of self compassion in psychotherapy: The role of therapists' interventions. *Psychotherapy Research*, *30*(6), 815–828. https://doi.org/10.1080/10503307.2019.1650979

Gao, S., Assink, M., Cipriani, A., & Lin, K. (2017). Associations between rejection sensitivity and mental health outcomes: A meta-analytic review. *Clinical Psychology Review, 57*, 59–74. https://doi.org/10.1016/j.cpr.2017.08.007

Girard-Joyal, O., & Gauthier, B. (2022). Creativity in the predominantly inattentive and combined presentations of ADHD in adults. *Journal of Attention Disorders, 26*(9), 1187 1198. https://doi.org/10.1177/10870547211060547

Greene, R. W., Biederman, J., Faraone, S. V., Ouellette, C. A., Penn, C., & Griffin, S. M. (1996). Toward a new psychometric definition of social disability in children with attention deficit hyperactivity disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *35*(5), 571–578. https://doi.org/10.1097/00004583-199605000 00011

Goffnett, J., Liechty, J. M., & Kidder, E. (2020). Interventions to reduce shame: A systematic review. *Journal of Behavior Therapy*, *50*(1), 42–61. https://doi.org/10.1016/j.jbct.2020.03.0011 ...

Harpin, V. A., Mazzone, L., Raynaud, J. P., Kahle, J., & Hodgkins, P. (2016). Long-term outcomes of ADHD: A systematic review of self-esteem and social function. *Journal of Attention Disorders, 20*(4), 295–305. https://doi.org/10.1177/1087054713486516

Hume, R. (2022). Show me the real you: Enhanced expression of Rogerian conditions in therapeutic relationship building with autistic adults. *Autism in Adulthood, 4*(2), 151–163. https://doi.org/10.1089/aut.2021.0065

Hussain, A. (2024). *Social-Emotional Outcomes in Emerging Adults with ADHD: The Influence of Self-Compassion on Peer Rejection, Rejection Sensitivity, and Psychological Distress* (Publication No. 2628) [Master's thesis, Wilfrid Laurier University]. Scholars Commons @ Laurier. https://scholars.wlu.ca/etd/2628

Huynh, G., Masood, S., Mohsin, H., & Daniyan, A. (2024). The impact of late ADHD diagnosis on mental health outcomes in females. *Social Sciences & Humanities Open*, *10*, 100977. https://doi.org/10.1016/j.ssaho.2024.100977

Iudici, A. (2014). The Use of the ADHD Diagnostic Label: What Implications Exist for Children and Their Families? *Procedia - Social and Behavioral Sciences*, *122*, 506–509. DOI: 10.1016/j.sbspro.2014.01.1383

Jones, F., Hamilton, J. and Kargas, N. (2024) Accessibility and affirmation in counselling: An exploration into neurodivergent clients' experiences. *Counselling and Psychotherapy Research*, *(add volume number),*1–16. https://doi.org/10.1002/capr.12742

Karalunas, S. L., Antovich, D., Goh, P. K., Martel, M. M., Tipsord, J., Nousen, E. K., & Nigg, J. T. (2021). Longitudinal network model of the co-development of temperament, executive functioning, and psychopathology symptoms in youth with and without ADHD. *Development and Psychopathology*, *33*, 1803–1820. https://doi.org/10.1017/S0954579421000900

Kofler, M. J., Sarver, D. E., Harmon, S. L., Moltisanti, A., Aduen, P. A., Soto, E. F., & Ferretti, N. (2017). Working memory and organizational skills problems in ADHD. *Journal of Child Psychology and Psychiatry, 59*(1), 57–67. https://doi.org/10.1111/jcpp.12773

Kroll, E., Lederman, M., Kohlmeier, J., Kumar, K., Ballard, J., Zant, I., & Fenkel, C. (2024). The positive impact of identity-affirming mental health treatment for neurodivergent individuals. *Frontiers in Psychology*, *15*, 1403129. https://doi.org/10.3389/fpsyg.2024.1403129

Lewis, M. (2024). An exploration of the ways in which person-centered counselors' diagnoses of attention-deficit/hyperactivity disorder (ADHD) can challenge or support their practice. *Person-Centered & Experiential Psychotherapies, 23*(2), 203-221. https://doi.org/10.1080/14779757.2023.2297384

Luo, Y., Weibman, D., Halperin, J. M., & Li, X. (2019). A Review of Heterogeneity in Attention Deficit/Hyperactivity Disorder (ADHD). *Frontiers in Human Neuroscience*, *13*, 42. https://doi.org/10.3389/fnhum.2019.00042

Mazzone, L., Postorino, V., Reale, L., Guarnera, M., Mannino, V., Armando, M., Fatta, L., De Peppo, L., & Vicari, S. (2013). Self-esteem evaluation in children and adolescents

suffering from ADHD. *Clinical Practice and Epidemiology in Mental Health: CP & EMH*, *9*, 96–102. https://doi.org/10.2174/1745017901309010096

Mikami, A. Y., Smit, S., & Khalis, A. (2017). Social skills training and ADHD—What works? *Current Psychiatry Reports, 19*(11), Article 93. https://doi.org/10.1007/s11920-017 0850-2

Mischel, W., & Shoda, Y. (1995). A cognitive-affective system theory of personality: Reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. *Psychological Review, 102*(2), 246–268.https://doi.org/10.1037/0033-295X.102.2.246

Mitchell, D. N. C. (2022). Value exploration of the counselor: A narrative approach for supervision. *Counseling and Values*, *67*(1), 23–43.

Mogendorff, K. (2013). The Blurring of Boundaries between Research and Everyday Life: Dilemmas of Employing One's Own Experiential Knowledge in Disability Research. *Disability Studies Quarterly*, *33*(1).

Mullan, J. (2023). *Decolonizing therapy: Oppression, historical trauma, and politicizing your practice*. W. W. Norton Professional.

Neff, K. D. (2023). Self-compassion: Theory, method, research, and intervention. *Annual Review of Psychology*, *74*, 193–218. https://doi.org/10.1146/annurev-psych-032420031047

Nijmeijer, J. S., Minderaa, R. B., Buitelaar, J. K., Mulligan, A., Hartman, C. A., & Hoekstra, P. J. (2008). Attention-deficit/hyperactivity disorder and social dysfunctioning. *Clinical Psychology Review*, *28*(4), 692–708. https://doi.org/10.1016/j.cpr.2007.10.003

Nyström, A., Petersson, K., & Janlöv, A. C. (2020). Being different but striving to seem normal: The lived experiences of people aged 50+ with ADHD. *Issues in Mental Health Nursing, 41*(6), 476–485. https://doi.org/10.1080/01612840.2019.1695029

Safren, S. A., Sprich, S., Perlman, C. A., & Otto, M. W. (2005). *Mastering your adult ADHD.* Oxford University Press. https://doi.org/10.1093/med:psych/9780195188196.001.0001

Sáez-Francàs, N., Alegre, J., Calvo, N., Ramos-Quiroga, J. A., Ruiz, E., Hernández-Vara, J., & Casas, M. (2012). Attention-deficit hyperactivity disorder in chronic fatigue syndrome patients. *Psychiatry Research, 200*(2–3), 748–753. https://doi.org/10.1016/j.psychres.2012.04.041

Shapero, B. G., Gibb, B. E., Archibald, A., Wilens, T. E., Fava, M., & Hirshfeld-Becker, D. R. (2021). Risk factors for depression in adolescents with ADHD: The impact of cognitive biases and stress. *Journal of Attention Disorders, 25*(3), 340–354. https://doi.org/10.1177/1087054718797447

Shaw, P., Stringaris, A., Nigg, J., & Leibenluft, E. (2014). Emotion dysregulation in attention deficit hyperactivity disorder. *American Journal of Psychiatry, 171*(3), 276–293. https://doi.org/10.1176/appi.ajp.2013.13070966

Soler-Gutiérrez, A.-M., Pérez-González, J.-C., & Mayas, J. (2023). Evidence of emotion dysregulation as a core symptom of adult ADHD: A systematic review. *PLOS ONE*, *18*(1), e0280131. https://doi.org/10.1371/journal.pone.0280131

Steindl, S., Bell, T., Dixon, A., & Kirby, J. N. (2023). Therapist perspectives on working with fears, blocks and resistances to compassion in compassion focused therapy. *Counselling and Psychotherapy Research*, *23*, 850–863. https://doi.org/10.1002/capr.12530

Sugarman, A. (2019). The importance of considering development when analyzing patients with adult ADHD: Commentary on Whiteside. *The Psychoanalytic Study of the Child*, *72*(1), 118–130.

Taylor, J. H., Poole, S., Rodway, R., & Tyson, R. (2006). Parallel Process in Supervision: A qualitative investigation. *European Journal for Qualitative Research in Psychotherapy*, (1), 10-20.

Turville, L. (2024). Understanding neurodiversity in therapeutic spaces: Client experiences of misattunement and validation [Master's thesis, York University].

Uekermann, J., Kraemer, M., Abdel-Hamid, M., Schimmelmann, B. G., Hebebrand, J., Daum, I., & Kis, B. (2010). Social cognition in attention-deficit hyperactivity disorder (ADHD). *Neuroscience & Biobehavioral Reviews, 34*(5), 734–743. https://doi.org/10.1016/j.neubiorev.2009.10.009

van der Putten, W. J., Mol, A. J. J., Groenman, A. P., Radhoe, T. A., Torenvliet, C., van Rentergem, J. A. A., & Geurts, H. M. (2024). Is camouflaging unique for autism? A comparison of camouflaging between adults with autism and ADHD. *Autism Research*, *17*(4), 812–823. https://doi.org/10.1002/aur.3099

Whitman, L. (2019). “Using a Spoon to Claw Your Way Out of a Steel Cage”: A Candidate Works with the Frustration and Defeatism of a College Student with Inattentive ADHD= and Depression. *The Psychoanalytic Study of the Child*, *72*(1), 71–87. https://doi.org/10.1080/00797308.2019.1557484

Williams, S., Horrocks, M., Richmond, J., Hall, C. L., & French, B. (2024). Experience of CBT in adults with ADHD: A mixed methods study. *Frontiers in Psychiatry, 15.* https://doi.org/10.3389/fpsyt.2024.1341624

Williams, O. C., Prasad, S., McCrary, A., Jordan, E., Sachdeva, V., Deva, S., Kumar, H., Mehta, J., Neupane, P., & Gupta, A. (2023). Adult attention deficit hyperactivity disorder: A comprehensive review. *Annals of Medicine & Surgery*, *85*, 1802–1810. https://doi.org/10.1097/MS9.0000000000000631

Zetzer, H. A., Hill, C. E., Hopsicker, R. J., Krasno, A. M., Montojo, P. C., Winter Plumb, E. I., Hoffman, M. A., & Donahue, M. T. (2020). Parallel Process in Psychodynamic Supervision: The Supervisor's Perspective. *Psychotherapy*, *57*(2), 252–262. https://doi/org/10.1037/pst0000274