

**Entwined Realities:
Storying AuDHD in Young Adults**

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Abstract

This research proposal outlines a potential study to deepen current understandings of the lived experiences of young adults diagnosed with co-occurring autism spectrum disorder and attention deficit/hyperactive disorder. Prevalence estimates underscore the extent of this overlap: 30–80% of autistic people present with clinically significant attention deficit/hyperactive disorder symptoms, and 20–50% of those with attention deficit/hyperactive disorder exhibit autistic traits above diagnostic threshold. Until the recent decade, the two could not be diagnosed as co-occurring. The current treatment protocols for this unique diagnostic co-occurrence involves applying methods from the protocols of each diagnosis, yet it is unclear if this piecemeal approach is effective. This gap in clinical application and research is what this study seeks to address. Using a narrative inquiry approach, the proposed study intends to centre participants' voices and analyse their experiences of psychotherapy through the Acceptance and Commitment Therapy framework. Acceptance and Commitment Therapy has proven its transdiagnostic effectiveness across various studies and shows promise to support this unique population. This proposed study seeks to contribute to neuroaffirming approaches to care by supporting neurodiverse young adults diagnosed with co-occurring autism spectrum disorder and attention deficit/hyperactivity disorder.

Keywords: Autism spectrum disorder, attention deficit/hyperactive disorder, acceptance and commitment therapy, narrative inquiry, neurodiversity

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Introduction

Young adults with co-occurring autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) face distinct and compounded challenges that can extend beyond those associated with either one. Pronounced challenges during this developmental period are related to individuals' emotional regulation skills, heightened stress, and executive functioning (van der Meer et al., 2012; Antshel et al., 2013). As these individuals transition from adolescence into adulthood, there is mounting pressure caused by increased demands in social domains, executive functioning, academia, and occupational needs (Aydin et al., 2023; Craig et al., 2016; Goetz & Adams, 2023; Hartman & Hartman, 2024). Although there is growing recognition of this neurodevelopmental profile (Antshel & Russo, 2019; Baranova et al. 2022; Carta et al., 2020) there remains a notable gap in evidence-based interventions designed to address the complex interplay of challenges these young adults experience (Antshel et al., 2013; Christiansen et al., 2023).

To meaningfully address this gap, it is essential to adopt a conceptual framework that reflects how individuals understand these intersecting diagnoses. In this proposal, the terms *neurodivergence* and *AuDHD* will be used frequently. Neurodivergence refers to variations in cognitive functioning that diverge from dominant social norms, encompassing descriptions such as autism, ADHD, and others (Craddock, 2024; Murray et al., 2023). Although AuDHD is not yet widely recognized in formal diagnostic manuals or widely used in peer-reviewed research, it is increasingly employed within neurodivergent communities to describe the co-occurrence of ASD and ADHD, particularly in online advocacy and clinical spaces. Its usage reflects a growing recognition that existing categorical systems may be insufficient for capturing lived experience, and that community driven language can play a critical role in shaping more responsive clinical

frameworks. Grounded in the neurodiversity paradigm, this perspective emphasizes that neurodevelopmental differences are not inherently pathological but represent meaningful forms of human variation (Craddock, 2024; Murray et al., 2023). In doing so, it challenges deficit-based models and underscores how barriers often arise not from individual traits but inflexible systems—such as inaccessible communication methods, rigid protocols, or assumptions rooted in neurotypical norms.

A potentially effective treatment that matches the neurodivergent orientation is Acceptance and Commitment Therapy (ACT) which theorizes that much of psychopathology is rooted from a lack of psychological flexibility (Hayes et al. 1999). Hayes et al., (2006) define psychological flexibility as the ability to make contact with the present moment while engaging in behaviour that is aligned with personal core values. Studies and clinicians using the ACT framework have demonstrated effectiveness in domains like emotional regulation and stress management across various clinical populations (A-Tjak et al.2015; Gloster et al.2020), including autistic people (Pahnke et al., 2019) and ADHD people (Beck et al., 2020) separately. However, its potential utility for individuals with co-occurring AuDHD remains unexplored (Christiansen et al., 2023). The proposal being presented explores this potential of ACT based psychotherapy as a way to serve this population in an individual therapy context.

The research question which grounds this proposal is: *How do young adults with AuDHD describe their lived experiences of individual psychotherapy guided by the ACT model?* The proposed study aims to address this question and contribute to the development of neuroaffirming tailored interventions that may improve the well-being and daily functioning of this underserved and underrepresented population. A detailed literature review will contain expanded descriptions of ASD, ADHD, and AuDHD. The literature review will also review ACT

to build the argument for it being an effective model for AuDHD young adults. Following the literature review will be an explanation of the methodology for the research project. Finally, a discussion addressing clinical practice and research implications will conclude the proposal.

Literature Review

The databases used to identify relevant literature included the; City University of Seattle library database, EBSCO eBook collection, Taylor and Francis Mental Health and Social Care collection, EBSCO Psychology and Behavioral Sciences Collection, APA PsychInfo, PubMed, and SAGE premier. Searches used combinations of keywords such as “attention deficit/hyperactivity disorder”, “autism spectrum disorder”, “acceptance and commitment therapy”, “ASD/ADHD co-occurrence”, “neurodiversity”, “neuroaffirming care”, “treatment protocols”, and “narrative inquiry”. Articles were included if they were peer-reviewed, published within the last 15 years (with some earlier seminal works), and directly addressed ASD, ADHD, or their co-occurrence. Priority was given to studies focusing on young adulthood or developmental transitions and those examining neurocognitive, social, emotional, or treatment aspects of functioning. Exclusion criteria involved non-peer reviewed sources (with the exception of clinically significant texts), studies limited to animal models or unrelated comorbidities, and research focusing exclusively on populations outside of adolescence and young adulthood.

ASD and ADHD are two of the most common neurodevelopmental conditions. Though they frequently co-occur, both present distinct diagnostic challenges. Hallmark characteristics for ASD include social and communication difficulties, restrictive and repetitive patterns of behaviour, and differences in cognitive and sensory processing with varying phenotypic presentations (Brosnan & Ashwin, 2023; Norbom et al., 2025; Zapparrata et al., 2022). ASD is

estimated to affect approximately 2% of the population, though prevalence can vary based on diagnostic criteria, geographic region, and study methodology (Antshel & Russo, 2019; Antshel et al., 2013; da Silva et al., 2020; van der Meer et al., 2012; Young et al., 2020). Hallmark characteristics of ADHD include the following: difficulties in attention and focus regulation (hyperactivity/inattention), emotion regulation, and impulsive behaviour (hyperactivity) (Baranova et al., 2022). ADHD is reported in approximately 5% of children and adolescents and 2–3% of adults globally, with variations seen across cultures and age cohorts (Antshel et al., 2016; Antshel et al., 2013; Vasiliadis et al., 2024; Song et al., 2021; Young et al., 2020).

ASD and ADHD are classified as distinct neurodevelopmental presentations each capable of causing significant difficulties throughout the lifespan, specifically during developmental transitions such as adolescence and early adulthood (APA, 2024; Aydin et al., 2023; Hartman et al., 2016; van der Meer et al., 2012). Recognition of their substantial overlap in traits and presentations led to the DSM-V revision allowing for a co-occurring diagnosis (Ameis, 2017; Antshel & Russo, 2019; Antshel et al., 2016; Baranova et al., 2022; Carta et al., 2020; Dellapiazza et al., 2021; Hartman et al., 2016). Individuals with the co-occurring diagnoses may experience compounded challenges in executive functioning, emotional regulation, sensory sensitivities, social interactions, cognitive processing, and working memory, making tasks of daily living significantly more demanding (Ameis, 2017; Antshel & Russo, 2019; Antshel et al., 2016; Brosnan & Ashwin, 2023; Mikami et al. 2019; Zapparrata et al., 2022). Prevalence estimates underscore the extent of this overlap: 30–80% of autistic people present with clinically significant ADHD symptoms, and 20–50% of those with ADHD exhibit autistic traits above diagnostic threshold (Hours et al., 2022; Rong et al., 2021; Russell et al., 2014; van der Meer et al., 2012). Similarly, Baranova et al. (2022) report that 13% of youth diagnosed with ADHD

have comorbid ASD, and 40-70% of youth diagnosed with ASD also meet ADHD criteria. Collectively, these findings suggest the two may share parallel etiological underpinnings.

A review by Mikami et al. (2019) underscored the growing need for transdiagnostic understanding and concomitant treatment of ADHD and ASD, identifying social functioning as a central area of overlap. Mikami et al. (2019) differentiated the two by suggesting that autistic individuals struggle with *knowing what to do* in social situations, whereas individuals with ADHD struggle with *doing what they know*. However, alternative models emphasize broader neurocognitive and self-regulatory overlaps, including difficulties in executive functioning, emotional regulation, sensory and cognitive processing, and social interaction (Antshel et al., 2013; Craig et al., 2016; van der Meer et al., 2012). Recent evidence illustrates how such overlaps may mask important qualitative distinctions: for example, adults with ADHD tend to show heightened affective verbal output under conditions of dysregulation, whereas those with co-occurring ADHD and ASD demonstrate more constrained emotional and action-related language production, suggesting distinct underlying mechanisms (Walter et al., 2023). These challenges, which can include difficulties with working memory, impulsivity, and heightened sensory sensitivities, vary widely among individuals, reflecting heterogeneity and complex interplay of traits in AuDHD (Ameis, 2017; Antshel & Russo, 2019; Brosnan & Ashwin, 2023; Dellapiazza et al., 2021; Lau-Zhu et al., 2019; van der Meer et al., 2012; Zapparrata et al., 2022). Rather than a primarily behavioural distinction, these findings support a more dimensional perspective of ASD and ADHD grounded in overlapping neurodevelopmental traits.

Late adolescence and early adulthood represent pivotal developmental periods for the maturation of executive functioning, emotional regulation, and sensory processing (Aydin et al., 2023; Shakeshaft et al., 2023). For individuals with AuDHD, delays or disruptions in these

domains can persist into adulthood, compounding the demands of increased academic, occupational, and social expectations (Hartman & Hartman, 2024; Shakeshaft et al. 2023). Such challenges heighten vulnerability to both externalizing difficulties (e.g., impulsivity, disorganization, and emotional outbursts), and internalizing experiences (e.g., anxiety, depression, social withdrawal), as well as risks for increasing vulnerability to mood disorders, anxiety disorders, substance use, inter alia (Antshel et al., 2013; da Silva et al., 2022; Fossum et al., 2021). The interplay of these difficulties underscores the urgent need for early identification and flexible, person-centered interventions that address the diverse and evolving needs of this population (Norbom et al., 2025; Shakeshaft et al., 2023)

There is an ongoing debate in the literature regarding whether ASD and ADHD should be conceptualized as distinct diagnostic entities or as different manifestations of a shared underlying neurodevelopmental condition (Ameis, 2017; Antshel & Russo, 2019; Craddock, 2024; Norbom et al., 2022; Rommelse et al., 2016; van Der Meer et al., 2012). Several studies argue for the evidence of maintaining ASD and ADHD as distinct, rigid, categorical differences due to their distinct core features, developmental trajectories, and treatment needs. For example, Antshel et al. (2013) and Antshel and Russo (2019) highlight that while there is considerable overlap in symptoms, cognitive profiles, and comorbidity patterns, the conditions differ meaningfully in etiology and response to intervention. Specifically, Antshel and Russo (2019) emphasize ADHD as being associated with dopaminergic dysfunction and fronto-striatal abnormalities, whereas ASD presents with broader and more heterogeneous neurodevelopmental disruptions involving social brain networks and connectivity differences (Antshel & Russo, 2019). These divergent underpinnings contribute to differences in intervention efficacy: pharmacological treatments, particularly stimulants, are generally effective in reducing core symptoms of ADHD, but show

limited benefits and increased risk of adverse effects when used with autistic individuals (Antshel et al., 2013). Similarly, Ameis (2017) emphasizes the heterogeneity that exists both within and between ASD and ADHD, supporting the need for distinct classifications to guide personalized approaches to diagnosis and care.

A growing body of evidence challenges rigid categorical distinctions and supports the view that ASD and ADHD may represent phenotypic expressions of a single overarching disorder. Rommelse et al. (2016), Norbom et al. (2022), Norbom et al. (2025), van der Meer et al., (2012), cite converging findings across cognitive, symptom, and population-level studies that reveal significant overlaps that support this view. Rommelse et al. (2016) introduce the step-function endophenotype model, which posits that individuals cluster at discrete levels of cognitive dysfunction that align with, but also blur, traditional diagnostic boundaries. Norbom et al. (2022) further validate this model by showing that these cognitive steps are paralleled by structural and functional neurobiological features—highlighting cross-disorder mechanisms. Such findings support a shift toward mechanism-based diagnostic frameworks, where both shared and disorder-specific processes are mapped and targeted. Importantly, these authors do not deny meaningful differences in presentation and treatment response but argue that a dimensional, cross-disorder perspective better reflects clinical reality. Craddock (2024) advances this argument by critiquing categorical nosology, suggesting that it often obscures the dynamic and intersecting nature of neurodevelopmental conditions and dimensional frameworks may better account for individual variability and lived experience. Latent structure analyses similarly reveal intermediate or combined subtypes that resist neat categorization (e.g., Antshel et al., 2013), further complicating efforts to draw strict diagnostic lines.

Support for a shared underlying profile is especially compelling in genetic research. Twin and family studies have long demonstrated high heritability for both ASD and ADHD, with substantial genetic correlation suggesting shared liability (Antshel et al., 2013; Antshel & Russo, 2019). For example, van der Meer et al. (2012) report overlapping genetic factors that contribute to the co-expression of autistic and ADHD traits. Rommelse et al. (2010) reinforce this view by emphasizing that shared genetic architecture likely underpins comorbid symptoms at both categorical and dimensional levels. More recently, large-scale genetically informed studies, such as Ghirardi et al. (2021), confirm that common inherited variants contribute to both conditions and their frequent co-occurrence. Shakeshaft et al. (2023) build on this by demonstrating that these genetic influences persist into early adulthood, shaping the developmental trajectory of AuDHD traits. Further, polygenic risk score analyses (da Silva et al., 2020; Norbom et al., 2025; Young et al., 2020) show significant overlap in genetic risk for both disorders, lending further support to dimensional models and shared etiological pathways. These overlapping pathways likely contribute to the complex phenotypic interplay seen in AuDHD individuals. At the same time, distinct genetic markers associated with hallmark features—such as social communication challenges in ASD or hyperactivity-impulsivity in ADHD—help account for heterogeneity (Antshel et al., 2016; Ameis, 2017).

Exploration of endophenotypic diversity within and across both diagnoses thus becomes crucial to advancing understanding of AuDHD. Ultimately, this genetic research lends substantial weight to the argument that ASD and ADHD are best viewed as different developmental outcomes emerging from partly shared, partly distinct neurobiological foundations.

Taken together, this growing body of evidence—from cognitive, neurobiological, and

especially genetic domains—underscore the value of dimensional and integrative models in capturing the complexity of autism, ADHD and AuDHD. Appreciating the balance of shared and unique pathways can deepen our understanding of individual variability and move the field beyond rigid categorical frameworks. This nuanced perspective is essential when considering treatment: without accounting for the intertwined etiologies and overlapping mechanisms, interventions risk being overly generalized or misaligned. With this dimensional, person-centered view on neurodiversity in mind, the following section considers treatment recommendations that prioritize individualized and responsive support strategies.

Treatment Recommendations

The current therapeutic approach to AuDHD is a piecemeal approach, taking interventions from evidence-based treatments for ASD and ADHD and seeing what works. To better understand the current state of treatment recommendations, brief summaries and critiques of each ASD and ADHD treatments are subsequently explained. Following, will be a discussion of the piecemeal approach commonly used for AuDHD individuals and the resulting implications for this proposed study.

ASD

Treatment approaches for ASD emphasize the importance of early, individualized, and multi-modal interventions (Eckes et al., 2023; Gerow et al., 2022). Caregiver training and family centered interventions are also highlighted as effective means of promoting adaptive functioning (Schuck et al., 2022; McGill & Robinson, 2020). Educational and community-based supports, including school accommodations and structured teaching, play a vital role in supporting development (Francis et al., 2016; Schuck et al., 2021). Authors note the importance of addressing sensory sensitivities and emotion regulation difficulties through targeted interventions

(Dellapiazza et al., 2021) as well as gender informed adaptations to treatment to account for under-recognized presentations, particularly in females (Green et al., 2019; Song et al., 2021). Ultimately, integrated care models and equitable access to evidence-based supports remain critical priorities for autistic individuals (Reiersen & Todd, 2008).

Behavioural strategies such as Applied Behavioural Analysis (ABA) have strong empirical support focusing on communication, social skills, and reduction of challenging behaviours (Eckes et al., 2023; Gerow et al., 2022). ABA is most widely used in ASD treatment; however, critiques have become increasingly prominent, especially from autistic individuals themselves who argue that the intervention prioritizes surface-level behavioural conformity over genuine well-being (McGill & Robinson, 2020). McGill and Robinson (2020) highlight how traditional ABA approaches emphasize compliance and extinguishing behaviours that are deemed socially undesirable, even when such behaviours may be adaptive responses to sensory overload or emotional distress. This emphasis can inadvertently promote masking which has been linked to increased anxiety, depression, and trauma symptoms in autistic populations. These concerns are echoed in *Is This Autism?* (Henderson et al. 2023), where the authors document numerous cases in which autistic individuals internalized the message that their natural way of being was wrong, leading to long-term psychological harm and diminished autonomy. Collectively, these accounts challenge the assumption that behavioural compliance equals success and instead advocate for supports that honour neurodivergent identities and promote autonomy and self-determination. As Henderson et al. (2023) described, the goal of behavioural approaches is to make the person less autistic, as if being autistic is inherently wrong and something to be fixed.

In this discussion, it is important to address the empirical evidence supporting ABA.

Often, this evidence is focused on caregiver experiences and even those are mixed, due to both perceived benefits and emotional burdens of intensive ABA (Giambona et al. 2023). Broader concerns about ABA research include potential conflicts of interest, sponsorship bias, and selective outcome reporting (Bottema-Beutel et al., 2021), as well as associations with increased post-traumatic stress symptoms (Kupferstein, 2018). Kupferstein (2018) found that as parents' satisfaction of ABA intervention outcomes increased, post traumatic stress symptoms in their autistic children increased. Recent work has called for integrating neurodiversity perspectives to address these limitations and ensure alignment with autistic values (Schuck et al., 2021, 2022). Overall, autism has traditionally been viewed as a problem to be fixed, rather than an example of variation in neurodevelopment of humans (Henderson et al., 2023; Kupferstein 2018; McGill & Robinson 2020; Price 2022). While certain adaptations of ABA may provide support in helping families navigate the complex challenges that can accompany autism, they are not universally appropriate. This is especially the case when autism is framed as something to be treated or eliminated rather than understood as a valid form of human diversity.

ADHD

Literature on ADHD treatment recommendations showcase the strength of pharmacological interventions, primarily stimulants, offering rapid improvements in attention and impulse control by targeting dopaminergic and noradrenergic systems (Antshel & Russo, 2019; da Silva et al., 2023; Young et al., 2020). These medications are particularly effective in the short term but may produce side effects like sleep issues or appetite loss, and their long-term impact on functional outcomes remains mixed (Antshel et al., 2013; Antshel et al., 2016; Vasiliadis et al., 2024). As a result, medication is typically recommended within a broader, multimodal treatment plan.

Behavioural interventions, including Cognitive Behavioural Therapy, school or workplace accommodations, and family-based approaches, play a critical role in supporting executive functioning, emotion regulation, and adaptive skills (Antshel & Russo, 2019; Francis et al., 2016; McGill & Robinson, 2020; Schuck et al., 2021; Vasiliadis et al., 2024). While these strategies may not reduce core symptoms as quickly as medication, they foster long-term development and are most effective when individualized and consistently applied across settings. (Antshel et al., 2013; Antshel et al., 2016). Gender and developmental differences also shape treatment responses, echoing patterns observed in autism. (da Silva et al., 2023; Song et al., 2021). Although cognitive behavioural therapy is commonly recommended for ADHD, standard protocols may not fully accommodate the sensory, emotional and cognitive needs of this population, requiring thoughtful adaptation to be effective (Kerns et al., 2016; Young et al., 2020). The work of Vasiliadis et al. (2024) found that not receiving effective treatment for ADHD has a significant impact on all-cause mortality. This phenomenon has implications for diagnosis and treatment planning (Ameis, 2017; Vasiliadis et al., 2024; Stevens et al., 2016).

AuDHD

The treatment of AuDHD is primarily extrapolated from established practices for ASD and ADHD, emphasizing individualized, symptom-focused, and multi-modal interventions that tend to be grounded in a deficit orientation. No standardized or evidence-based treatments have been validated specifically for the co-occurrence of ASD and ADHD (Antshel & Russo, 2019; van der Meer et al., 2012; Ameis, 2017). Many existing protocols for ASD and ADHD prioritize behavioral compliance and symptom reduction or elimination—an approach that may inadvertently contribute to the harm reported by AuDHD individuals. These models often operate within a deficit-based framework that reject the reality that ASD, ADHD, and AuDHD

reflect valid neurobiological differences rather than pathologies to be corrected. This lack of neuroaffirming, client-centered treatment options underscore a significant gap—one that this proposal seeks to address. The following section of the literature review will explore how ACT offers a flexible, process-based approach that can support AuDHD individuals, regardless of the theoretical lens through which clinicians view their diagnoses.

Acceptance and Commitment Therapy

ACT is a transdiagnostic, process-based psychological intervention rooted in functional contextualism (FC) and relational frame theory (RFT) (Hayes et al., 1999; Hayes 2004; Hayes et al., 2006). FC involves examining the historical and situational context of behaviour to guide its understanding and influence, with the ultimate goal of predicting and affecting psychological events with precision, scope, and depth (Hayes et al., 2006). Observing psychological events through the lens of FC means they are ongoing processes within an individual, which act on and are influenced by situational and historical contexts (Hayes et al., 2006).

RFT describes how humans learn to make meaning by linking experiences, words, and ideas together in systematic ways. Unlike simple associations (e.g., learning that fire is hot through touch), RFT emphasizes that people can derive new meanings without direct experience, simply through learned relations. For example, a child can understand that a dime is worth more than a nickel even though it is physically smaller (Hayes et al., 1999; Hayes, 2004). This ability makes language and reasoning highly flexible, but it can also create rigid and painful self-judgments. For instance, a young adult with AuDHD may learn relational patterns such as “struggling to focus means I am lazy” or “not fitting in means I am broken.”. ACT builds on RFT by helping individuals notice these learned patterns and reduce their influence, creating space for more flexible, values-guided ways of living.

ACT is intended to enhance psychological flexibility (Hayes et al., 2006) and its efficacy and transdiagnostic applicability has been shown through meta-analytic findings (A-Tjak et al., 2015). Hayes et al. (2006) described ACT as diagnosis-agnostic as a result of its focus on underlying processes rather than directly targeting behaviour or disorder specific symptoms. Thus, compliment both categorical frameworks which emphasize distinct etiologies and treatment pathways of ASD, ADHD and AuDHD (Ameis, 2017; Antshel et al., 2013; Antshel & Russo, 2019), and the mechanism-based frameworks, which highlight shared cognitive and neurobiological mechanisms across conditions (Rommelse et al., 2016; Norbom et al., 2022; van der Meer et al., 2012). For young adults with AuDHD, whose needs often straddle both frameworks, ACT's emphasis on process-oriented, individualized intervention offers a promising approach. In particular, its components—mindfulness, acceptance, and values clarification—have shown potential in enhancing emotion regulation, reducing stress, and supporting executive functioning (Hayes et al., 2006; Francis et al., 2016).

ACT is grounded in FC, which allows a practitioner to view psychological events as whole actions-in-context (Hayes et al., 2006), rather than isolated symptoms, and thus supports a flexible, idiographic approach to intervention. RFT posits that language processes—such as self-concept, comparison, and evaluation—can contribute to psychological inflexibility when fused with rigid behavioural patterns (Hayes et al., 2001). ACT uses experiential techniques to weaken the dominance of these relational frames, fostering greater cognitive and behavioural flexibility through its six interrelated processes: acceptance, defusion, present-moment awareness, self-as-context, values clarification, and committed action. Together, these processes support individuals in stepping back from unhelpful thoughts, opening up to difficult experiences, and engaging more fully with self-defined meaningful activities. This theoretical foundation allows ACT to

move beyond symptom reduction or surface level behavioural elimination to emphasize meaning-making, values-based action, and contextual sensitivity. For young adults with AuDHD, this means recognizing and working with the dynamic interplay between past learning histories, present struggles, and future aspirations.

Literature conclusions

This literature review has synthesized current evidence underscoring the significance of AuDHD and the complexity inherent in its presentation. It has also brought to light a notable gap in tailored interventions, leaving clinicians with limited guidance when treatment planning for the unique and compounding challenges faced by this population. Given its distinctive philosophical and theoretical foundations, ACT offers a flexible, transdiagnostic framework that may be well-suited to meet the nuanced needs of young adults with AuDHD as they navigate increasing developmental demands across various domains of adulthood.

Further, this review builds a case for recognizing AuDHD as a distinct or, at least, meaningful neurodevelopmental profile (Norbom et al., 2022; Norbom et al., 2025; Rommelse et al., 2010; van der Meer et al., 2012). It emphasizes the need for dimensional and person-centered assessment frameworks in place of rigid categorical distinctions (Craddock, 2024; Lau-Zhu et al., 2019; Shakeshaft et al., 2023). Gender-related disparities in diagnosis further complicate the clinical picture of AuDHD. ASD and ADHD are more commonly diagnosed in males than females, with reported ratios of approximately 4:1 and 2:1, respectively (da Silva et al., 2023; Lord et al., 2022; Song et al., 2021). However, research suggests that these differences may be shaped by gendered presentations and socialization patterns. Females are more likely to internalize symptoms and develop masking strategies, particularly when language and cognitive development fall within typical ranges (Green et al., 2019; Young et al., 2020; Lundin et al.,

2021). As a result, many go undiagnosed or are misdiagnosed, often with conditions like borderline personality disorder (Darling Rasmussen, 2022). In addition, gender-diverse individuals are significantly more likely to be neurodivergent, with elevated rates of ASD and ADHD reported across global samples (Goetz & Adams, 2022; Warrier et al., 2020; Zhang et al., 2020). The term *Autigender*, popularized by Price (2022), reflects how some autistic individuals experience gender in uniquely neurodivergent ways—highlighting the need for inclusive and nuanced clinical frameworks that move beyond binary norms.

The values-driven approach of ACT is especially relevant given the current limitations in available interventions for this population. Many existing approaches remain ill-equipped to address the combined and overlapping challenges experienced by individuals with AuDHD. For example, Kupferstein (2018) raises important concerns about the potential harm caused by ABA, particularly when applied without sensitivity to the individual. Most evidence-based treatments remain designed for either ASD or ADHD in isolation, rather than their co-occurring presentation (Antshel et al., 2016; Antshel & Russo, 2019). By centering lived experiences within the ACT framework, I am seeking to address this gap by proposing a study that offers preliminary insight into how such an approach may support this complex neurodevelopmental profile. In doing so, it responds to broader calls in the literature for diagnostic humility and flexibility—urging clinicians to move beyond categorical labels and instead attend to the unique constellations of strengths and needs presented by each individual (Craddock, 2024; Norbom et al., 2025).

Rather than focusing on the direct outcomes or efficacy of ACT or measuring the reduction of individuals autistic or ADHD traits, this proposed study aims to explore the lived experiences of individuals who have engaged in ACT-based therapy. Such an approach

integrates participants' voices and stories into the literature and aligns with the values of the neurodiverse/AuDHD community—focusing on empowerment and adaptation, rather than reduction or elimination of neurodivergent traits.

Methods

The research question guiding this proposal is: *How do young adults with AuDHD describe their lived experiences of individual psychotherapy guided by the ACT model?* While the research and literature based on ASD and ADHD are vast, the proposed study seeks to address the lack of participatory research and representation in the ASD and ADHD literature (Fletcher-Watson et al., 2019). Fletcher-Watson et al. (2019) share valuable insight on this aforementioned lack by highlighting the disconnect between the research community and the autistic community. The article conveyed that historically autism research has overlooked autistic lived experience, perspectives, and priorities. For example, research is often focused on biology and causation rather than on issues that affect autistic people's day-to-day lives. It also tends to frame autism through a deficit-based model of impairment or pathology, instead of recognizing strengths, identity, and neurodiverse perspectives. Craddock (2024) similarly discusses this disconnect in the way clinicians and researchers portray autism and ADHD from a research and diagnostic lens. Accordingly, the proposed study prioritizes the narratives of young adults with AuDHD in psychotherapy, aiming to foreground their perspectives rather than impose externally defined measures of change (Craddock, 2024; Fletcher-Watson et al., 2019).

It is in this context that the proposed study would be informed by a narrative approach, which views personal experience as storied and shaped through social and contextual interaction (Clandinin & Connelly, 2000). From this perspective, meaning is not fixed or universal, but constructed through the ways the individuals interpret, retell, and reflect on their experiences

over time (Clandinin & Connelly, 2000). This approach aligns with the theoretical foundations of ACT, also drawing upon FC as its guiding philosophical perspective (Hayes, 1993; Hayes et al., 2006). FC focuses on how useful knowledge is in real life. It values ideas that help us understand and influence behaviour in specific situations. From this view, an idea is considered “true” if it works – if it helps someone take effective action that fits with their values in their own context.

Furthermore, narrative inquiry is grounded in the understanding that humans make sense of their lives through stories (Riessman, 2008). Narrative inquiry focuses on the ways individuals construct and convey meaning through their personal narratives, particularly how they interpret events, relationships, and internal experiences over time (Riessman, 2008). This approach is not merely about collecting life stories—it involves examining the structure, context, and function of stories to understand how people negotiate identity, agency, and change. It is rooted in relational, temporal, and contextual dimensions, recognizing that experience is shaped by social, cultural, and historical forces (Clandinin & Connelly, 2000). Through narrative analysis, participants are positioned as meaning-makers rather than subjects of diagnostic categorization, and their voices are honored as central sources of knowledge.

This narrative orientation is especially relevant to the proposed study, which examines how AuDHD individuals make meaning of their therapeutic experiences. ACT, for example, emphasizes values-driven action and contextual sensitivity, making it a fitting model for exploring agency in neurodivergent clients. Yet, autistic and ADHD perspectives—particularly those reflecting on psychotherapy—remain underrepresented and often filtered through deficit-based frameworks. Narrative inquiry centers participants voices and values, allowing them to articulate identity, change, and therapeutic impact in their own words. By focusing on stories of

engaging with ACT, this methodology highlights heterogeneity and generates insights grounded in lived experience rather than imposed clinical interpretations.

Narrative interviews will be used to generate in-depth, retrospective accounts of participants' experiences with ACT. These interviews will create space for participants to articulate personal reflections, shifts in values or behaviour, and the lived impact of ACT processes over time.

Design

The proposed study would unfold over a 24-week data collection period, during which each participant will engage in three interviews: early stage, late stage (Week 12), and a follow-up interview (Week 24). This design is informed by Clandinin and Connelly's (2000) emphasis on relational and temporal engagement, which encourages repeated interactions with each participant to build trust and capture the evolving nature of the experience. Clandinin and Connelly's (2000) emphasis on temporal depth and co-construction in narrative inquiry, situating participants not just as subjects but as co-authors in the meaning-making process. Next is a breakdown of inclusion and exclusion criteria as well as other participant related information, data collection protocol, and data analysis protocol.

Participants

The study will use purposive sampling, a non-probability sampling strategy commonly used in qualitative research to deliberately select participants who have rich, relevant, and diverse experiences related to the phenomena under investigation (Creswell & Poth, 2018). Purposive sampling enables the researcher to identify individuals who can offer deep insight into the research question and supports a depth-over-breadth approach that is aligned with narrative methodology (Creswell & Poth, 2018). A sample of 5-8 young adults (aged 18-25) with formal

diagnoses of co-occurring ASD and ADHD is proposed. The size is sufficient to allow for in-depth exploration of individual narratives while remaining feasible for a solo research project and consistent with recommendations for narrative inquiry (Cresswell & Poth, 2018).

Recruitment will occur through two primary pathways. First, outreach will be conducted through local community organizations and post-secondary institutions such as Autism Calgary and The Sinneave Family Foundation, with outreach designed to connect with neurodivergent young adults seeking therapeutic support (see Appendix A). Recruitment materials will be designed to connect with neurodivergent young adults who are seeking therapeutic support and who may be interested in ACT-based therapy. Second, ACT-trained and neuroaffirming therapists in Alberta will be contacted and invited to share study information with potentially eligible clients in the early stages of treatment. To protect confidentiality and minimize coercion, therapists will serve only as intermediaries by distributing recruitment materials, and interested clients will be instructed to contact the researcher directly (see Appendix B).

Because the study centers on experience of ACT-based therapy, it is essential to ensure that participants are receiving services from appropriately credentialed professionals. As such, verification will be sought that the therapist is licensed to practice in Alberta (e.g., College of Alberta Psychologists or other recognized regulatory body) and has formal training in ACT, such as entry-level certification or documented experience delivering ACT-informed interventions.

Inclusion criteria for participation include a formal diagnosis of co-occurring ASD and ADHD, age between 18-25, willingness to engage in ACT-based therapy, and diversity in gender expression and communication styles. Exclusion criteria include self or informal diagnosis, concurrent participation in other forms of individual psychotherapy, and the presence of intellectual disability or other traits that would preclude informed consent or meaningful

engagement in narrative interviews. This recruitment strategy and eligibility process are designed to ensure methodological coherence, ethical engagement, and reflexivity, while safeguarding participant autonomy and protecting against analytic overreach or bias.

Data Collection

Data will be generated through three semi-structured narrative interviews with each participant across a 24-week period: an early-stage interview, another immediately following the 12 weeks of ACT therapy (Week 12) and then a follow-up 12 weeks later (Week 24). Consistent with narrative inquiry's relational and temporal commitments, this repeated engagement is designed to build trust and capture the unfolding nature of experience (Clandinin & Connelly, 2000). Interviews will privilege participants' own language, pacing, and storylines; prompts will be open-ended and minimally directive, in line with Riessman (2008), allowing narrative accounts to develop with minimal imposition of external structure.

The early-stage interview will consist of basic questions to learn about the participants current life context, history of therapy, and establish rapport. The late-stage interview (see Appendix D) will consist of participants' narrative accounts of their experience in ACT (e.g., turning points, helpful/unhelpful processes, barriers/facilitators, meaning made during and after sessions). The follow-up interview (see Appendix E) will inquire about reflections on what has persisted or shifted since therapy ended, how insights were applied to daily life, and opportunities to revise/clarify earlier accounts—honouring participants as co-authors of their narratives (Clandinin & Connelly, 2000).

The semi-structured interview guides were developed by synthesizing core principles of narrative inquiry outlined by Clandinin and Connelly (2000), Creswell and Poth (2018), and Riessman (2008). These authors emphasize open-ended, minimally directive prompts that

encourage participants to tell their stories in their own words, while allowing flexibility for the conversation to follow the participants' narrative trajectory. Guided by three meta-questions—"What is this person's story?", "What meaning do they make from these experiences?", and "What does this experience mean to them and their lives?"—the guide was structured to move from broad life context to therapy experiences, to meaning-making and reflection over time. This design supports the proposed study's aim to center participants' voices, preserve their narrative coherence, and create space for rich, detailed accounts for lived experience.

All interviews will be conducted in a quiet, participant-preferred setting (secure video call is acceptable), audio-recorded with consent, and supported by researcher field notes documenting context, nonverbal cues (where observable), and emergent analytic memos. Participants may optionally bring artifacts (e.g., journal entries, personal notes, fidget toys, or any comforting personal effects they wish) if they believe these will help tell their story; these will be treated as contextual aides rather than primary data unless explicitly consented as such.

Positionality Statement

Before outlining the approach for data analysis, it is important to clarify my positionality to provide transparency around how my lived experience informs and shapes this work. I am a white settler, cis-heterosexual man, with financial privilege, and a former national team athlete. These intersecting identities afforded me opportunities that helped mitigate the challenges I experienced as a neurodivergent person myself. I was diagnosed later in adulthood, and the process of receiving a diagnosis had a profound impact on my self perception and the way I engage with the world. During my adolescence and early adulthood, I experienced many of the compounding challenges outlined in the literature, including difficulties with executive functioning, identity formation, and navigating social expectations—albeit buffered by the support

I was privileged to access. As a national team athlete, I was able to attend a high school that could accommodate my needs as an athlete which concurrently provided the accommodations I needed as a neurodivergent person, despite being undiagnosed.

I also bring professional experience from my recent internship, where I have had the opportunity to work with young adults diagnosed with co-occurring ASD and ADHD. I have basic training in ACT, and I have witnessed firsthand how ACT-based interventions can support individuals in this population. My personal experiences with therapy, mindfulness, and values work—particularly through my yoga teacher training and athletic background—have given me a deeply embodied understanding of ACT, beyond the academic or clinical lens. I have personally experienced the transformative impact of clarifying and living in alignment with my values, which closely aligns with ACT’s philosophical core.

While my experiences offer valuable insight, they also present potential sources of bias. My positive personal experience with psychotherapy and ACT, combined with my passion for supporting neurodivergent individuals, may predispose me to favour narratives that align with ACT’s efficacy. This could result in confirmation bias—overemphasizing affirming narratives while minimizing neutral or critical accounts. Additionally, my identification with neurodivergent participants could lead to over-identification or projection, assuming similarity in experiences where differences may actually exist. Finally, because values-based living has been so transformative in my own journey, I may be inclined to prioritize participant accounts that mirror this pathway, thereby unintentionally marginalizing alternative or conflicting perspectives.

To mitigate these risks, I intend to adopt several reflexive and ethical research strategies. These include maintaining a reflective research journal throughout data collection and analysis,

engaging in regular peer debriefing and seeking consultation with a trusted supervisor. In particular, I plan to collaborate with a supervisor to review participant narratives and ensure I remain open to diverse interpretations, including those that challenge my assumptions. These strategies will help ensure analytic rigor and enhance trustworthiness in the interpretation of findings.

My positionality also contributes positively to this research in several ways. First, my lived experience of navigating the world as a late-diagnosed neurodivergent person fosters a deep empathy and rapport with participants, which can enhance the quality of narrative interviews. Second, my familiarity with ACT's theoretical foundations and its clinical application equips me to recognize nuanced themes in participant narratives related to values, acceptance, and psychological flexibility. My embodied understanding of mindfulness and values work—through yoga and athletics—adds further depth to my interpretive lens. Ultimately, my personal and professional experience position me to conduct this research with sensitivity, curiosity, and a commitment to amplifying neurodivergent voices with integrity.

Data Analysis

Data will be analyzed using a narrative thematic approach (Riessman, 2008), with an emphasis on both the content of participants' stories and the ways in which these stories are structured, revised, and sequenced over time. The researcher will begin by reading each transcript holistically, alongside field notes, to develop a within-case narrative synopsis for each participant, preserving plotline, temporal, sequencing, and contextual details from the pre-treatment, post-treatment and follow-up interviews. Initial coding will identify meaning-laden episodes, metaphors, and evaluative statements related to ACT processes (e.g., values clarification, acceptance, cognitive defusion) and their perceived impacts. Attention will be given

to temporal changes, continuities, and contradictions, including moments participants re-story or consolidate earlier accounts.

After within-case analysis, thematic patterns will be synthesized across participants while retaining the integrity of individual narratives. Variations and negative cases will be noted to enhance analytic depth and trustworthiness. Reflexivity will be maintained through a researcher journal, documenting assumptions, decisions, and potential biases, and an audit trail will support transparency in the analytic process (Clandinin & Connelly, 2000; Creswell & Poth, 2018).

Where appropriate, participants will be invited to review narrative summaries or key excerpts as part of an optional reflection process. Final representations will present themes embedded within coherent narrative accounts, with quotations integrated contextually to preserve the flow and meaning of participants' stories.

Ethical considerations

Informed consent processes are critical to both research and clinical practice and must take into consideration how executive functioning and communication differences can influence comprehension and decision-making (Dellapiazza et al., 2021). Ensuring that consent procedures are fully understood by participants is essential. This will include giving participants time to review consent documents independently, followed by a joint review with the researcher to clarify questions and confirm understanding (see Appendix F). Centering agency and autonomy throughout this process aligns with participatory research principals, which seek to better serve neurodivergent populations. Fletcher-Watson et al. (2019) recommend that researchers remain open to adapting their methods and incorporating perspectives of autistic people, their allies, and family members. Fletcher-Watson et al. (2019) address how open dialogue regarding research

methods can help contextualize the process. Thus, make it more transparent to those outside academia which this proposed study seeks to accomplish.

The study design intentionally incorporates a 12-week period following therapy, allowing participants time to reflect on their experiences, add new insights, and/or request removal of material. This is particularly relevant given evidence that differing processing needs and deliberative reasoning are core characteristics for many neurodivergent individuals (Brosnan & Ashwin, 2023; Zapparrata et al., 2022). Informed consent will include a clear explanation of the study design, the nature of narrative methodology, how interviews will be recorded, how data will be stored securely, and the process for deletion of materials upon study completion. Participants will be informed that they may withdraw their consent at any point, including after data analysis has begun, and will be asked whether they consent to the use of non-identifiable quotations to enrich the analysis and findings.

Confidentiality will be upheld through the de-identification of all demographic information and interview content. Audio files will be transcribed verbatim by the researcher to ensure accuracy, and all transcripts will be de-identified and stored on encrypted, password-protected drives. Only the researcher and supervisor will have access to raw data. Any contextual details that might inadvertently identify participants will be altered or omitted while maintaining the integrity of the narrative. In keeping with narrative ethics, participants will be invited to review narrative summaries or key excerpts as part of an optional reflection process (Clandinin & Connelly, 2000).

In this proposed study, therapists will be required to prove through clinical branding, by definition, or examples of, whether they align with neuroaffirming approaches to care—recognizing neurodiversity as a natural variation in human experience, avoiding deficit-based

framing, and adapting therapeutic strategies to honour each participant's identity and needs. While shared ACT principles will form the framework of the intervention, specific therapeutic decisions and in-session adaptations will remain within the therapist's professional judgement to ensure responsiveness to client needs and alignment with their ethical codes of practice. This approach balances the need for methodological coherence with allowance for professional autonomy. The researcher will not direct, supervise, or evaluate clinical decisions; instead, consistency will be supported through a pre-study orientation outlining the agreed-upon ACT processes and neuroaffirming values to be incorporated.

To alleviate participant burden, interviews and therapy sessions may be conducted either virtually or in-person, according to participant preference. Participants will have direct contact information for the researcher in case of questions or concerns, and participation in the study will be at no cost.

This study is guided by a commitment to cultural humility, respect for neurodiversity, and awareness of how intersecting identities influence lived experience. Participants' voices and self-definitions will be prioritized, and deficit-based language will be avoided. Efforts will be made to recruit inclusively across gender identities, socioeconomic backgrounds, and cultural contexts by approaching various organizations during recruitment. The findings will be presented in a manner that is accessible and respectful to the communities represented, with the intention of supporting broader understanding and equitable therapeutic practices.

Discussion

This section reflects on the broader significance of the proposed study by examining ethical and cultural considerations, outlining key implications and applications, and acknowledging the proposed study's limitations. In particular, it considers how exploring

AuDHD experiences through narrative inquiry and an ACT framework contributes to more neurodiversity-affirming research and clinical practice.

Ethical and Cultural Considerations

The risk of misdiagnosis remains pervasive as current diagnostic tools are primarily validated on cisgender male, white, western populations (Antshel & Russo, 2019; da Silva et al., 2023; Green et al., 2019; Lee & Lee, 2023). This creates disproportionate barriers for females, gender diverse, non-binary, and transgender individuals, who are at greater risk of being overlooked during the diagnostic process (Goetz & Adams, 2022; Rong et al., 2021; Darling Rasmussen, 2021; Song et al., 2021; Young et al., 2020; Zhang et al., 2020). Addressing these inequities requires diagnostic protocols that are inclusive and sensitive to cultural and gender diversity.

The compounded challenges of AuDHD, including difficulties related to emotional regulation and executive functioning, can be further exacerbated by socioeconomic and cultural barriers to care. Antshel et al. (2013) called for accessible, affordable and culturally competent interventions as being central to the ethical issues surrounding treatment.

This research proposal expresses an intentional choice to avoid pathologizing language. This is a challenging but necessary shift, as much of the literature and clinical discourse on autism and ADHD remains framed through a deficit lens. Such framing risks obscuring strengths, adaptive strategies, and resilience that many neurodivergent individuals possess (Norbom et al., 2025; Shakeshaft et al., 2023). Hogan (2019) highlights that developing awareness of the social determinants of health enables healthcare providers to deliver care that is more responsive to the communities they serve. Reframing neurodivergence to account for both

strengths and societal barriers calls for more neuroaffirming, strengths-based approaches to care—an orientation central to this proposed study.

Study Implications

The synthesis of literature and conceptual framing presented here points to several critical implications for the research literature. The findings reinforce a growing body of evidence advocating for a dimensional, transdiagnostic understanding of neurodevelopmental profiles. (Lau-Zhu et al., 2019; Shakeshaft., 2023; van der Meer et a., 2012). Moving beyond rigid categorical frameworks allows for more precise identification of overlapping and distinct traits in AuDHD and supports development of interventions that target shared mechanisms. Early adulthood emerges as a particularly vulnerable developmental window during which the cumulative effects of executive functioning challenges, emotional dysregulation, and sensory sensitivities become more pronounced (Orm et al., 2022; Fossum et al., 2021). This underscores the need for longitudinal and developmental research to determine optimal intervention windows.

The literature further highlights persistent structural inequities in diagnostic and treatment access, particularly for gender-diverse populations, due to reliance on cisnormative, male-centric diagnostic frameworks (da Silva et al., 2023; Goetz & Adams, 2022; Young et al., 2020). Research in this area must therefore intentionally recruit diverse samples to ensure that findings are representative and broadly applicable. By examining ACT as a diagnostic-agnostic, process-based intervention, the proposed study could contribute to expanding the evidence base for approaches that can address the heterogeneity of AuDHD presentations without reinforcing deficit-based models (Hates et al., 2006; A-Tjak et al., 2015). Collectively, these implications

strengthen the theoretical foundation for developing neuroaffirming, person-centered approaches and provide a roadmap for future inquiry in this domain.

Study Applications

Addressing this research question has direct and measurable applications for clinical practice, educational, and public health initiatives. In clinical contexts, the findings could support ACT in its transdiagnostic use (A-Tjak et al., 2015; Francis et al., 2016; Gloster et al., 2020; Hayes et al., 2006; Pahnke et al., 2019; Seery et al., 2024) and the diagnostic-agnostic nature of it (Hayes et al., 2006). Potential adaptations to the ACT model may be developed to address the unique needs observed in AuDHD populations, such as integrating sensory modulation strategies and executive functioning supports. Recent evidence underscores why such tailoring is necessary: Walter et al. (2023) found that while adults with ADHD often produce heightened affective and action-related language under conditions of dysregulation, those with AuDHD demonstrate more constrained emotional and action-related word use. These divergent profiles suggest that ADHD-only presentations may benefit from interventions targeting impulsive emotional reactivity and over-expression, whereas AuDHD presentations may require strategies that build emotional awareness, vocabulary, and embodied expression. This aligns with reflexive practice, encouraging clinicians to critically examine their own biases, particularly around deficit-based framing and the use of outdated diagnostic criteria, while remaining responsive to client narratives and needs.

The proposed study could broaden the evidence base for process-based interventions that are adaptable to complex, overlapping neurodevelopmental presentations. Clinically, the study could inform assessment protocols, treatment planning, and professional training modules that emphasize person centered assessment, recognition of overlapping traits, and acknowledgement

of the limitations of current diagnostic tools (Antshel et al., 2013; Shakeshaft et al., 2023).

Educational and workplace contexts could benefit from the adoption of accommodations such as sensory-friendly environments, flexible deadlines, and structured task supports (Fossum et al., 2021; Hartman & Hartman, 2024; Orm et al., 2022), directly contributing to societal well-being by creating environments that respect neurodiversity and reduce barriers to participation.

At a policy level, the study would provide a foundation for advocating for more inclusive diagnostic criteria, equitable service delivery, and neurodiversity-affirming environments (Ameis, 2017; Antshel & Russo, 2019; Henderson et al., 2023). Public health initiatives could leverage these insights to promote early, developmentally responsive interventions informed by the lived experience of neurodivergent individuals (Kupferstein, 2018; Price, 2022; Warriar et al., 2020). By integrating these applications, the study bridges reflexivity, scientific and clinical knowledge, and societal well-being, ensuring that findings translate into tangible, equity-oriented change (Brosnan & Ashwin, 2023; Rea et al., 2024).

Finally, this study would lay a foundation for future research and policy development. There is a pressing need for longitudinal studies that follow individuals with AuDHD across the lifespan to better inform intervention timing, targets, and developmental trajectories (Norbom et al., 2025). Insights from such work could guide the evolution of diagnostic frameworks and shape public health strategies that acknowledge heterogeneity, emphasize early and responsive supports, and reduce systemic barriers. In doing so, the proposed study could contribute not only to immediate clinical and policy practice but also to the broader goal of building equity-oriented, neurodiversity-affirming systems of care.

Limitations

Several limitations must be acknowledged. Much of the existing evidence on AuDHD

originates from Western, high-income contexts and may not generalize globally without cultural adaptation (Antshel & Russo, 2019). The ways in which neurodevelopmental conditions are understood, labeled, and supported vary considerably across cultural contexts, and these differences must be considered when interpreting findings. Methodologically, the reliance on secondary literature synthesis may limit the inclusion of emerging, unpublished, or community-based perspectives, particularly those from marginalized groups underrepresented in academic research. The high heterogeneity in AuDHD phenotypes also means that even evidence-based interventions like ACT require substantial individual tailoring, which constrains generalizability of broad recommendations. The diversity of AuDHD presentations makes it impossible to create a one-size-fits-all approach. Furthermore, the proposed study would only be capable of supporting a small portion of individuals diagnosed with AuDHD. Finally, as with all narrative-oriented approaches, researcher interpretations are shaped by positionality. Reflexive practices, including transparent documentation of analytic decisions and peer debriefing, would be essential to mitigate the influence of bias on findings and their interpretation.

Conclusion and Future Directions

The framing of this proposed study highlights that while neurodiverse profiles can be disabling in the current societal context, the vast heterogeneity and diverse phenotypic presentations within these profiles remain poorly understood among clinicians and researchers. An individual's experiences and challenges cannot be dismissed simply because they do not conform to a rigid categorical description or a biased diagnostic framework. AuDHD is complex, and both the individual diagnoses (ADHD and ASD) and their co-occurrence are more prevalent than once thought. A progressive, dimensional understanding of these conditions must be adopted across clinical, research, and educational settings.

Significant gaps remain in the literature that warrant further investigation. AuDHD presents as a distinct neurodevelopmental profile with compounding challenges beyond those seen in either autism or ADHD alone. Future research must determine whether autism and ADHD represent phenotype variations of an overarching dimensional neurodevelopmental condition, and if not, how such a high co-occurrence and overlap of traits can be explained. Furthermore, greater attention must be given to how societal forces—including gender socialization and cultural context—shape the ways these diagnoses present and are perceived.

The urgency for accurate and progressive understandings is further underscored by the rapid growth of online autistic and ADHD communities. While these spaces can offer valuable peer support and knowledge sharing, they are also susceptible to the spread of misinformation. A quick search of autism or ADHD on any major social media platform yields an overwhelming range of content, from highly accurate to entirely false. Studies such as the one proposed here are vital for providing evidence-based clarity, shaping contemporary discourse, and influencing progressive research trajectories.

For meaningful change to occur, systemic reform in clinical and educational practice is essential. Clinicians, educators, and policymakers must center the voices of neurodivergent individuals, moving away from deficit and disability models toward neuroaffirming frameworks. Professional training modules should emphasize person-centered assessment, the limitations of current diagnostic tools, and the need to recognize overlapping and distinct traits across autism and ADHD (Antshel et al., 2013; Shakeshaft et al., 2023). Universities must also adapt their curricula to reflect contemporary, evidence-based understandings of autism, ADHD, and AuDHD, ensuring that the next generation of clinicians is equipped to meet the needs of diverse neurodivergent populations.

If resource and systemic barriers were removed, the priority would be to conduct the proposed study in full, then expand its scope to contribute to the emerging theory that autism and ADHD may represent phenotypic presentations within a broader dimensional neurodevelopmental framework. The existing genetic, neurobiological, neuroimaging, and longitudinal evidence provides a strong foundation for this work, though comprehensive meta-analytic synthesis would be needed to consolidate findings and guide theory development. Looking ahead, my hope is that within the next decade, AuDHD will be more widely understood not as a deficit but as a natural expression of human diversity. This vision extends beyond neurodivergent populations to the broader recognition that societal, occupational, and educational demands are often excessive for any individual, and that robust, universally accessible supports are essential for fostering collective well-being (Hartman & Hartman, 2024)

AuDHD is a unique and complex neurodevelopmental profile, with compounding challenges that can place young adults at significant risk during the transition to adulthood (Fossom et al., 2021; Norbom et al., 2025; Orm et al., 2022). The need for tailored, flexible, and affirming treatment approaches for this population is urgent, yet often overlooked. As one autistic individual described:

In what other context does compensating for something mean that thing disappears?
 Someone with a broken ankle that uses a boot so they can continue to walk around still has a broken ankle...The burnout, the headaches, the crying, the dissociation, the pain, the exhaustion...you will probably never see it. That doesn't make it any less real, any less impactful, or any less valid (Henderson et al., 2023 p. 16).

These words serve as a reminder that the absence of visible difficulty does not equate to the absence of need. It is my hope that the proposed study will contribute to dismantling invalidating

perceptions, foster progressive research, and lay the groundwork for interventions and systemic changes that honour the lived realities of AuDHD and neurodiverse individuals, alike.

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Appendix A

Recruitment Email Template (To be sent to organizations)

To whom it may concern

My name is Adrian Cole and I am a graduate student at City University Seattle, Calgary Campus. I am conducting a research project as a part of my degree to explore the experiences and stories of young adults diagnosed with co-occurring autism spectrum disorder and attention deficit/hyperactivity disorder (AuDHD). This project is seeking to take a neuroaffirming approach to the research to contribute to the growing need for neuroaffirming approaches to care. If you know of any young adults between the ages of 18-25, who have received a formal diagnosis for the two co-occurring diagnoses, who would be interested in participating in this study, please have them reach out to me via email: coleadrian@cityuniversity.edu

I deeply appreciate your consideration in this matter, if you, or any potential candidates have any further questions please do not hesitate to reach out to me.

Kindly,
Adrian

Appendix B

Recruitment email template (To be sent to therapists)

To whom it may concern

My name is Adrian Cole, and I am a Master of Counselling graduate student at City University Seattle, Calgary Campus. I am conducting a research project as a part of my degree to explore the experiences and stories of young adults diagnosed with co-occurring autism spectrum disorder and attention deficit/hyperactivity disorder (AuDHD). This project is seeking to take a neuroaffirming approach to the research through narrative inquiry to contribute to the growing need for neuroaffirming approaches to care. If you know of any clients who are young adults between the ages of 18-25 and who have received a formal diagnosis for the two co-occurring diagnoses. Like any research study, potential candidates would be excluded if they are self-identifying as AuDHD (no formal diagnosis), if they are participating in con-current psychotherapy, or have been diagnosed with an intellectual disability. I am also aware of the varying communication styles of this group and as long as the participant can communicate in a way that does not impact narrative communication they would be considered. Additionally, this project is seeking to understand these individuals' *experience* of therapy through the acceptance and commitment therapy (ACT) framework. As such, if you are referring your clients to this study, you yourself will need to provide credentials or documentation of ACT training or delivery of ACT based interventions.

If you know any individuals who would be interested in participating in this study, please have them reach out to me via email: coleadrian@cityuniversity.edu

I deeply appreciate your consideration in this matter, if you, or any potential candidates have any further questions please do not hesitate to reach out to me.

Kindly,
Adrian

Appendix C

Early-stage Interview Guide (Week 0-2)

Purpose: Build rapport, gather life context, explore prior therapy experiences and expectations entering ACT.

1. **Life context**

- “Tell me about your life right now — what feels most important for me to understand about you?”
- “Can you share a story or example that captures what you do in a typical week?”

2. **History with therapy/supports**

- “Tell me about any times in the past when you’ve worked with a therapist or counsellor?”
- “What stands out for you from those experiences?”

3. **Living with AuDHD**

- “When did you first learn about your diagnoses, and how has that shaped your life story?”
- “Share a story about a time when you felt understood — or misunderstood — because of it?”

4. **Expectations for ACT**

- “As you start ACT, what are you hoping will happen?”
- “What would tell you, later on, that this was worth your time?”

Appendix D

Late-stage Interview Guide (Week 12)

Purpose: Explore experiences with ACT, perceived changes, challenges and moments of meaning.

- 1. Overall Experience**
 - “Looking back over the past 12 weeks, what stands out to you about your time in ACT?”
 - “Tell me about a specific moment in therapy that felt important?”
- 2. Therapy Processes**
 - “Was there something in ACT that you found especially helpful or unhelpful?”
 - “What changes do you notice in how you think about challenges or respond to them?”
- 3. Impact on daily life**
 - “Have you found yourself using ACT ideas outside of therapy? Can you share an example?”
 - “How have these weeks influenced how you see yourself or your future?”

Appendix E

Follow-up Interview Guide (Week 24)

Purpose: Explore sustained impacts, integration into life, and any revisions to earlier narratives

1. **Since therapy ended**
 - “What has life been like since we last spoke?”
 - “Have any of the changes you noticed after ACT stayed with you? Which ones?”
 - IF NONE: “Can you share with me more insight into why nothing from ACT has stayed with you? Why do you think that is?”
2. **Apply ACT concepts**
 - “Share a story about a time since therapy when you used something from ACT?”
 - IF NOT: “Tell me what you did use from your 12 weeks in therapy that wasn’t ACT related?”
 - “Have any challenges come up in applying what you learned?”
3. **Looking back at your earlier stories**
 - “When you think about what you told me before in our first interview, what would you add, change, or see differently now?”
 - “How has your self-understanding shifted or changed?”
 - IF NO FOR BOTH:
 - “What is next for you now that you have had a chance to reflect on this experience?”

Appendix F**CITYU RESEARCH PARTICIPANT INFORMED CONSENT****Title of Study:**

Analyzing the AuDHD Experience of Emerging and Young Adults: A Proposed Narrative Inquiry Using Narrative Thematic Analysis

Name and Title of Researcher(s):

Adrian Cole

For Student Researcher(s):

Faculty Supervisor: James Cresswell Ph.D

Department: School of Health and Social Sciences

Telephone: 587-880-4150

City U E-mail: calgary@cityu.edu

Program Coordinator (or Program Director):

Joseph Mills Ph.D

You are being invited to participate in a research study.

Key Information about this Research Study

The researcher will explain this research study to you before you will be asked to participate in the study and before you sign this consent form.

- Your participation is voluntary and you can decide not to participate or withdraw your participation at any time without penalty or negative consequences.
- It is your choice whether or not you want to participate in this research.
- The purpose of the research is to collect the experiences of young adults diagnosed with co-occurring autism spectrum disorder and attention deficit/hyperactive disorder in ACT based psychotherapy
- If you choose to participate you will be asked to participate in 3 data collection interviews as well as a 12 week ACT based psychotherapy intervention (once per week for 12 weeks).
- The risks or discomforts from this research include interacting with difficult emotions, exploring uncomfortable topics related to thoughts and experiences, sharing and discussing traumatic experiences, engaging with uncomfortable thoughts and feelings.
- The direct benefits of your participation are the potential to decrease stress, improve executive functioning, and improve well-being

You should talk to the researcher(s) about the study and ask them as many questions you need to help you make your decision.

What should I know about being a participant in this research study?

This form contains important information that will help you decide whether to join the study. Take the time to carefully review this information.

- You are eligible to participate in this study because you are: 18-25 years old, have obtained a formal diagnosis of co-occurring Autism Spectrum Disorder and Attention deficit/hyperactive disorder, are able to communicate in a way supportive to the study, are not participating in other psychotherapy concurrently, and have not been diagnosed with an intellectual disability.
- You will be in this research study for approximately 24 weeks
- About 5-8 individuals will participate in this study.

Why is this research being done?

Purpose of Study: The current treatment protocols for this unique diagnostic co-occurrence involve applying methods from the protocols of each diagnosis, but it is unclear if this piecemeal approach is effective. This gap in clinical application and research is what this study seeks to address.

Research Participation.

You will be asked to participate in the following procedures:

- One questionnaire with basic demographic information collection
- Three interviews: Pre-treatment 90 minutes (Week 0) post-treatment 90 minutes (Week 12) Follow-up 90 minutes (Week 24).
- 12 weeks of ACT based psychotherapy (one session per week 60 minutes approximately per session)

I understand I am being asked to participate in this study in one or more of the following ways (initial options below that apply. You may choose what options fit best for you.):

Respond to in-person; and/or, telephone/virtual Interview questions; Approximate time: 17 hours

Answer written questionnaire(s); Approximate time 30 minutes

Participate in a virtual video interview using this video program/app Zoom; Approximate time 17 hours

Other, specifically, _____. Approximate time _____

You may refuse to answer any question or any item in verbal interviews, written questionnaires or surveys, and, you can stop or withdraw from any audio or visual recording at any time without any penalty or negative consequences.

Are there any risks, stress or discomforts that I will experience as a result of being a participant in this study?

Taking part in this research involves certain risks: This could include experiencing difficult or uncomfortable thoughts and emotions, potentially re-visiting traumatic experiences, commonly in psychotherapy an initial worsening of symptoms such as anxiety and depression before an improvement.

Will being a participant in this study benefit me in any way?

We cannot promise any benefits to you or others from your participation in this research. However, possible benefits may include a stronger sense of self-understanding, a new values-based approach to life, improvement in well-being, improvement in emotional regulation, improved overall executive functioning.

You will receive _____ for your participation in this research.

You will not receive any payment for participation in this study.

Confidentiality

I understand that participation is confidential to the limits of applicable privacy laws. No one except the faculty researcher or student researcher, his/her supervisor and Program Coordinator (or Program Director) will be allowed to view any information or data collected whether by questionnaire, interview and/or other means.

If the student researcher's cooperating classroom teacher will also have access to raw data, the following box will be initialed by the researcher. AC

Steps will be taken to protect your identity, however, information collected about you can never be 100% secure. Your name and any other identifying information that can directly identify you will be stored separately from data collected as part of the research study. The results of this study will be published as a thesis and potentially published in an academic book or journal, or presented at an academic conference. To protect your privacy no information that could directly identify you will be included.

All data (the questionnaires, audio/video tapes, typed records of the interview, interview notes, informed consent forms, computer discs, any backup of computer discs and any other storage devices) are kept locked and computer files will be encrypted and password protected by the researcher. The research data will be stored for 5 years (5 years). At the end of that time all data of whatever nature will be permanently destroyed. The published results of the study will contain data from which no individual participant can be identified.

Signatures

I have carefully reviewed and understand this consent form. I understand the description of the research protocol and consent process provided to me by the researcher. My signature on this form indicates that I understand to my satisfaction the information provided to me about my participation in this research project. My signature also indicates that I have been apprised of the potential risks involved in my participation. Lastly, my signature indicates that I agree to participate as a research subject.

My consent to participate does not waive my legal rights nor release the researchers, sponsors, and/or City University of Seattle from their legal and professional responsibilities with respect to this research. I understand I am free to withdraw from this research study at any time. I further understand that I may ask for clarification or new information throughout my participation at any time during this research.

I have been advised that I may request a copy of the final research study report. Should I request a copy, I understand that I will be asked to pay the costs of photocopy and mailing.

Participant's Name: _____

Please Print

Participant's Signature: _____ Date: _____

Researcher's Name: Adrian Cole

Please Print

Researcher's Signature: _____ Date: _____

If I have any questions about this research, I have been advised to contact the researcher and/or his/her supervisor, as listed on page one of this consent form.

Should I have any concerns about the way I have been treated or think that I have been harmed as a research participant, I may contact the following individual(s):

Joseph Mills Ph.D., Program Coordinator (and/or Program Director), City University of Seattle,
at:

1040 7th Ave SW Suite 120, Calgary, AB T2P 3G9, Canada

587.880.4150

millsjoseph@cityu.edu

This study has been reviewed and has been approved by the Institutional Review Board (IRB) of City University of Seattle. If you have questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the IRB at IRB@Cityu.edu.