The co-occurrence of Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD): Investigating lived experiences of psychotherapy and sources of resilience

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Thesis submitted to Saint Paul University in partial Fulfillment of the requirements for the Master of Arts in Counselling and Spirituality

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Acknowledgments

I am deeply grateful to everyone who has contributed to the completion of this thesis. Firstly, I am incredibly grateful for the invaluable support, guidance, and insightful feedback from my supervisor, Dr. Yuanyuan Jiang, throughout this process. Your expertise, patience, and encouragement have been truly invaluable in making this possible. I have learned so much from you and am sincerely thankful for your mentorship! I would also like to sincerely thank my committee members, Dr. Stephanie Yamin and Dr. Laura Armstrong, for providing me with valuable feedback on this thesis. To my family and friends, thank you for being there for me during this journey and for supporting me every step of the way. To my parents, your constant support and encouragement have truly meant the world to me and have kept me going throughout this process. Thank you for always encouraging me to try my very best and work hard in all that I do. To my closest friends who have listened to me and been there for me through the many moments of stress, thank you. Especially my buddy throughout this program, Ikraam, I appreciate your constant support, for listening to my long voice notes, and for walking alongside me on this journey. In addition, I extend my sincerest gratitude to the participants who generously shared their experiences, time, and insights, without whom this research would not have been possible.

Finally, all praise and thanks are due to God for carrying me through this journey and making this possible. *And my success comes only through God (11:88).*

Abstract

Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) are neurodevelopmental conditions (NDCs) that can co-occur. This link has only been formally recognized in the past decade, as it was not until the publication of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) in 2013 that these conditions could be diagnosed together. Although more recent research has outlined the prevalence and challenges of this co-occurrence (Hours et al., 2022), limited research has captured how adults with such dual presentations experience psychotherapy. This qualitative study explores the lived experiences of adults with co-occurring ASD and ADHD who have received psychotherapy. Five participants completed a demographics questionnaire and a 60-minute semi-structured individual interview, exploring their experiences with psychotherapy as well as sources of resilience. Interviews were analyzed using an Interpretive Phenomenological Analysis (IPA) framework. Themes gathered included both positive and challenging experiences with therapy, sources of resilience, as well as participant recommendations. A total of 11 subordinate themes were identified, highlighting the importance of therapeutic alliance, individualized adaptations, and accessibility in psychotherapy for this population. Results of this study further broadens current understanding of therapeutic practices both clinically and scientifically, through better understanding lived experiences of a unique population. The findings represent an important step towards promoting future research and providing clinical guidance for neurodiversity-affirming interventions.

Introduction

Neurodevelopmental Conditions (NDCs)

Neurodevelopmental Conditions (NDCs) affect how the brain develops and functions, have their onset in the developmental period, and are lifelong in nature (Carlsson et al., 2021). These differences can impact individuals in a plethora of ways, including areas of behaviour, social engagement, and communication, which often lead to challenges in daily life. Consistent with diagnostic frameworks, clinically significant NDCs are defined by both symptoms and functional impairments in adaptive, academic, social, or occupational functioning (American Psychiatric Association, 2022). Empirical evidence further indicates that across single-diagnosis presentations, NDCs are associated with difficulties in adaptive functioning, including everyday personal, social, academic, and occupational skills (Isaksson et al., 2025). These findings underscore the central role of functional impairment in both diagnostic classification as well as lived experience.

Individuals with NDCs are also at greater risk for developing mental health concerns, due to an intricate combination of genetic and environmental factors (Carlsson et al., 2021). These environmental factors include, but are not limited to, greater challenges in social settings, daily life, academic and workplace settings, as well as stressors related to stigmatisation (Zhou et al., 2025). This elevated risk is well-established across single-diagnosis NDCs, with research indicating that approximately 70% of children with NDCs experience at least one co-occurring psychiatric condition, compared to about 15% of typically developing peers (Li et al., 2025).

While a single NDC increases mental health risk and overall challenges, the presence of more than one condition can intensify these challenges even further. Multiple NDCs may also interact in complex ways that result in a compounded effect on the individual. In fact, adaptive functioning difficulties have been shown to increase with the number of co-

occurring NDCs, indicating a cumulative impact on everyday skills (Isaksson et al., 2025). As such, those with co-occurring NDCs have been found to be at greater risk for additive behavioural, environmental, and biological challenges (Lai et al., 2019). These challenges can contribute to a greater tendency to adopting maladaptive coping strategies such as avoidance or emotional withdrawal, higher difficulty with self-regulation, and more pronounced challenges with executive functioning compared to individuals without NDCs (Arim et al., 2015; Hammud et al., 2023). These consequences can thereby lead to higher exposure to stressors in school environments, including peer rejection and academic difficulties (Hammud et al., 2023). Collectively, these proximal and distal factors can significantly affect mood, cognition, and behaviour, hence contributing significantly to mental health vulnerability. Indeed, many research studies have linked multiple NDCs to higher rates of mental health concerns. For instance, Zhou and colleagues (2025) analyzed data from the United States National Survey of Children's Health, and found that children aged 3-17 years of age with more than one NDC exhibited a higher prevalence and severity of depression and anxiety. This finding underscores the pressing need to better understand co-occurring NDCs and mental health concerns to better inform clinical practices and interventions.

Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) are two distinct NDCs that can substantially affect cognition, behaviour, and psychosocial functioning across the lifespan. Although traditionally conceptualized as separate diagnostic entities, increasing recognition of their overlap has highlighted the clinical relevance of co-occurring NDCs, particularly in relation to mental health vulnerability. The following sections first review ASD and ADHD individually, considering their associated mental health and functional challenges, before examining their co-occurrence to explore the unique complexities and implications for adults with both conditions.

Autism Spectrum Disorder (ASD)

Autism Spectrum Disorder (ASD) is an NDC that widely varies in presentation, functional ability, and severity across individuals. It is characterized by persistent difficulties in social communication and interaction, as well as the presence of restricted, repetitive patterns of behaviour, interests, or activities (Hodges et al., 2020). According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition – Text Revision (DSM-5-TR; American Psychiatric Association, 2022), diagnostic criteria for ASD requires evidence of deficits across three domains of social communication and interaction: social-emotional reciprocity, nonverbal communication, and relationship formation and maintenance. These must be present alongside at least two forms of restricted or repetitive behaviour, such as motor movements, insistence on sameness, fixated interests, and/or hypo- or hyper-reactivity to sensory input (American Psychiatric Association, 2022). These symptoms can present in various ways, with a range of severities, hence the conceptualization of the disorder as a spectrum within the DSM-5-TR. However, symptoms must be significant enough to cause impairment in social, occupational, and/or other important areas of functioning (American Psychiatric Association, 2022). Symptoms must also be present from early developmental periods, although they may not fully manifest until social demands increase, or may be masked due to learned behaviours (American Psychiatric Association, 2022).

It is also important to acknowledge that there is no universally agreed-upon way of referring to individuals on the Autism Spectrum. Preferences vary within communities, with some individuals favouring person-first language (e.g., “individual with autism”) and others preferring identity-first language (e.g., “autistic person”), reflecting differing perspectives on how autism is understood and integrated into a person’s sense of self (Kapp et al., 2013). In this paper, terminology is used respectfully and with flexibility, without implying superiority

of one form over another. Where possible, participants' own preferred language is reflected when describing their experiences.

Among childhood neurodevelopmental disorders, ASD is one of the most commonly diagnosed conditions. Indeed, according to global epidemiological estimates from the Global Burden of Disease Study in 2021, an estimated 61.8 million individuals worldwide, equivalent to one in every 127 people, are on the autism spectrum (Santomauro et al., 2024). ASD research and findings tend to be mainly focused on children compared to adults, with a review conducted by Howlin and Magiati (2017) reporting that only 3.5% of published research is centred on autistic adults. A potential cause for this paucity of research is due to the tendency for diagnosis to be earlier in life and during the developmental period (Howlin, 2021). Within Canada, the prevalence of ASD among adults is estimated to be 1.8% (Dietz et al., 2020), with a trend of increased diagnostic rates in recent decades, due to greater awareness, recognition, and broader definitions of diagnostic criteria (Collins et al., 2025). As such, many autistic adults may require ongoing support, while facing challenges in areas such as employment, social connection, and overall well-being (Collins et al., 2025).

Due to ASD being a lifelong condition, children who receive a diagnosis grow into adults who must navigate unique challenges in various domains. In particular, ASD puts individuals at greater risk for co-occurring mental health challenges. Research suggests that 70% of children with ASD have at least one co-occurring mental health condition, and 41% have two or more diagnosable conditions (Simonoff et al., 2008). Indeed, a meta-analysis by Lai et al. (2019), which synthesized data from 96 studies, revealed that among autistic populations, there is a much greater prevalence of other mental health conditions, compared to neurotypical populations. Co-occurrences found with ASD include Attention-Deficit/Hyperactivity Disorder (ADHD; 28%), anxiety disorders (20%), disruptive and conduct disorders (12%), depressive disorders (11%), obsessive-compulsive disorder (9%),

bipolar disorder (5%), schizophrenia spectrum disorders (4%), in addition to other disorders (Lai et al., 2019). Such prevalence rates are significantly higher than those observed in the general population (Dietz et al., 2020).

Anxiety is a particularly pervasive co-occurring condition among individuals with ASD, with studies showing that anxiety tends to fluctuate across the lifespan, rising from toddlerhood to childhood, declining in young adulthood, and increasing again in emerging adulthood (Davis et al., 2010). In particular, this association is observed due to pronounced deficits in social communication, along with increased efforts to engage in social situations through masking of autistic traits (Menezes et al., 2022). Totsika et al. (2011) further found in a parent-reported study that autistic youth, both with and without intellectual disabilities, were three to four times more likely to experience clinically significant emotional and conduct problems, compared to their neurotypical peers. Research also indicates that ASD severity is correlated with cognitive issues such as problems with performance on tests of verbal Intelligence Quotient (IQ), adaptive functioning skills, and perceptual processing skills (Mukherjee & Beresford, 2023).

The high rate in co-occurring mental health conditions among individuals with ASD is attributable to a complex interplay of cognitive, developmental, and socio-environmental factors. Adults with ASD have been found to have lower engagement in their communities as well as higher rates of unemployment and underemployment in comparison to the general population (Smith DaWalt et al., 2021). Socio-environmental stressors such as school-related experiences, discrimination and stigma in society, limited peer networks, and family disruptions have been found to significantly impact the well-being of autistic individuals (Mukherjee & Beresford, 2023). Taken together, this body of evidence demonstrates that ASD, even in the absence of additional neurodevelopmental conditions, is associated with

significant functional challenges and heightened risk for mental health difficulties across the lifespan.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-Deficit/Hyperactivity Disorder (ADHD) can significantly affect social and academic functioning. The DSM-5-TR (American Psychiatric Association, 2022) classifies ADHD as having three presentations: predominantly inattentive, predominantly hyperactive/impulsive, and combined presentation of inattentiveness and hyperactivity/impulsivity. The inattention domain includes but is not limited to, difficulty paying or sustaining attention, issues with following through on instructions, forgetfulness in daily activities, and distractibility. The hyperactive-impulsive domain includes but is not limited to, excessive talking, fidgeting, difficulty awaiting one's turn, impulsive speech, and acting without consideration of consequences. The combined presentation includes clinically significant symptoms from both the inattentive and hyperactive-impulsive domains. Similar to ASD, impairment must be significant enough to interfere with the quality of social, occupational, or other important areas of functioning (American Psychiatric Association, 2022). Symptoms must also persist for at least six months, with several symptoms being present before the age of 12, and presence in multiple settings. Importantly, the DSM-5 TR distinguishes between ADHD in children and adults through requiring six or more symptoms for children (16 or younger) and five or more symptoms for adults (17 or older) for both inattention and hyperactivity/impulsivity (American Psychiatric Association, 2022). This difference reflects a growing understanding of the presentation of ADHD as manifesting differently over the lifespan (Cortese et al., 2025).

Along with ASD, ADHD is also one of the most prevalent NDCs, with a prevalence of 2.9% among adults in Canada (Espinet et al., 2022). While ADHD was once believed to fade by adulthood (McGough & Barkley, 2004), a growing body of longitudinal research

reveals that symptoms frequently persist well beyond childhood. Studies estimate that between 50% and 78% of individuals diagnosed with ADHD in early life continue to experience clinically significant symptoms into adulthood and even into older age (Barkley et al., 2002; Hesson & Fowler, 2018). For example, in a 10-year longitudinal follow-up of children with ADHD into adulthood, 39% were found to have still exhibited clinically relevant ADHD symptoms in adulthood (Skogli et al., 2022). Furthermore, a meta-analysis conducted by Caye and colleagues (2016) found that childhood severity of ADHD, as well as comorbid conditions, are among the strongest predictors of persistence of ADHD into adulthood. Thus, these findings demonstrate that ADHD is a commonly persistent condition, with developmental implications across the lifespan. In addition, a notable number of adults have been found to receive an ADHD diagnosis for the first time in adulthood. Population data from the United States in 2023 estimates that 15.5 million adults had an ADHD diagnosis, with approximately half receiving their diagnosis after the age of 18 (Staley et al., 2024).

With respect to ADHD presentations, symptoms such as impulsivity, inattention, and hyperactivity are typically more overt in childhood. These features often persist into adulthood, although in modified forms. Hyperactivity in adults often manifests as feelings of inner restlessness, overscheduling, difficulty with relaxation (Cortese et al., 2025), as well as difficulty with organization and sustained attention (Faraone et al., 2000). Similarly, impulsivity in adulthood may be exhibited as acting without forethought in everyday decisions, such as rapid spending, sudden career or relationship changes, and challenges delaying gratification (Cortese et al., 2025). This presentation is frequently accompanied by increased novelty and sensation-seeking behaviors (Asherson et al., 2016), suggesting a shift to more internally driven or lifestyle-related presentations in adulthood compared to childhood.

These symptom patterns are often associated with significant functional challenges in adulthood. For instance, adults with ADHD have demonstrated poorer performance on executive functioning tasks compared to non-ADHD controls (Nigg et al., 2005). Research on functional impairment further indicates that adults with ADHD experience elevated difficulties across multiple domains, including daily functioning, academic performance, occupational functioning, as well as aspects of social functioning (Holst & Thorell, 2020). In adulthood, impairment areas extend beyond those typically observed in childhood and may include risky behaviours, interpersonal difficulties, underperformance in work or higher education settings, financial problems, unsafe driving, and challenges in parenting roles (Cortese et al., 2025). These functional difficulties are closely linked to underlying impairments in cognitive processes, and as a result, adults with ADHD are at an increased risk for adverse outcomes across key areas of adult functioning. These include employment instability, financial strain, relationship difficulties, lower self-esteem, and reduced academic attainment (Katzman et al., 2017). Consistent with these findings, evidence from a large community sample of 1,001 adults demonstrated that individuals with ADHD were significantly less likely to complete high school or obtain a college degree, were less likely to be currently employed, experienced more frequent job changes, and were more likely to be divorced. They also reported lower satisfaction across family, social, and professional domains compared to non-ADHD controls (Biederman et al., 2006). Thus, these findings illustrate the substantial and wide-ranging functional impact of ADHD in adulthood.

A growing body of literature suggests that ADHD across the lifespan is associated with a substantially increased risk of co-occurring psychiatric conditions. In adulthood in particular, the prevalence of comorbid psychiatric disorders is even higher (Ohnishi et al., 2019). For instance, in a large national sample of Canadians (n = 16,957), it was demonstrated that adults with self-reported ADHD (n = 488) exhibited significantly higher

rates of psychiatric comorbidity compared to age and gender matched controls (Hesson & Fowler, 2018). In particular, individuals with ADHD were more likely to report lifetime and current diagnoses of major depressive disorder, bipolar I and II disorders, generalized anxiety disorder, and substance use disorders. These findings are consistent with broader epidemiological evidence indicating elevated rates of mood, anxiety, and substance-related disorders among adults with ADHD, relative to the general population (Katzman et al., 2017; Ohnishi et al., 2019). Drawing on national survey data, Katzman et al. (2017) report that adults with ADHD are more than four times more likely to experience any mood disorder, three times more likely to develop major depressive disorder, six times more likely to develop persistent depressive disorder, and twice as likely to experience substance abuse or dependence, compared to adults without ADHD. Importantly, the co-occurrence of ADHD with other psychiatric conditions is associated with greater ADHD symptom severity, stronger impairments in daily functioning, increased health care needs, and higher mortality (Cortese et al., 2025). These comorbidities present important clinical challenges, as they contribute to greater clinical severity and complexity than ADHD alone (Ohnishi et al., 2019), underscoring the importance of comprehensive mental health care for individuals with ADHD across the lifespan.

Co-Occurring ASD and ADHD

Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) also frequently co-occur, with research indicating that 50 to 70% of individuals with ASD also meet the criteria for ADHD (Hours et al., 2022). This link has only been formally recognized in the past decade, as it was not until the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) in 2013 that these conditions were permitted to be diagnosed together (Young et al., 2020). Consequently, there may be many individuals who have gone undiagnosed or whose co-occurring conditions were missed during this time, underscoring

potential gaps in identification, support, and interventions. Since this change, growing empirical evidence has underscored the importance of understanding the unique presentation of individuals with both conditions. Epidemiological studies further highlight the prevalence and demographic characteristics of this co-occurrence. Using data from the National Survey of Children's Health in the United States, Casseus (2022) outlined that approximately 1.2% of children aged 3-17 years, or over 740,000 individuals, reported having both ASD and ADHD. Co-occurrence was more likely among male children, those with poorer reported general health, and those with public or mixed public-private health insurance. These findings reinforce prior clinical observations suggesting that ASD and ADHD co-occurrences are quite common and may present more frequently in more vulnerable populations. Furthermore, these findings may point to the potential for missed diagnoses, due in part to limited access to assessment services, through barriers related to health insurance access and other systemic challenges.

Given the DSM-5-TR's recognition of ASD as a spectrum and the heterogeneous nature of ADHD, it follows that their co-occurrence often results in wide variation in symptom presentation across individuals and across the lifespan. The manifestation of both is also often a distinct and more complex clinical presentation than either condition alone. Both also have strong genetic underpinnings, with evidence of co-occurrence within individuals and across family members (Rao & Landa, 2013). Research has shown that these difficulties are not only additive but also interactive, creating unique profiles that complicate both diagnosis and intervention (Hours et al., 2022; Leitner, 2014). From a developmental perspective, both conditions emerge early in life and can share overlapping features. These commonalities may include impaired executive functioning abilities, often reflected as challenges with regard to attention, impulsivity, and hyperactivity, along with communication challenges (Leitner, 2014; Craig et al., 2015). Such shared symptoms, particularly inattention

and executive dysfunction, can contribute to complications in differential diagnosis, leading to the delays and challenges for individuals in receiving accurate diagnoses (Rodríguez-Quiroga, et al., 2025).

The combination of both conditions exacerbates challenges in social, emotional, and educational domains (Accardo et al., 2024). Individuals with both ASD and ADHD exhibit a higher prevalence of depression and anxiety, heightened emotional dysregulation, more pronounced social difficulties, and increased risk of suicide (Accardo et al., 2024; Al Ghamdi & AlMusailhi, 2024). Recent national data from the United States, analysed by Accardo et al. (2024), highlights the significant mental health burden faced by adolescents with co-occurring ASD and ADHD. Anxiety rates were very high, with 72% of autistic females and 69% of autistic males with ADHD reporting co-occurring anxiety, figures higher than those observed in individuals without either diagnosis. Depression was also seen to be highly prevalent, with 38-39% of both male and female autistic adolescents with ADHD meeting criteria for depression, compared to just 3.6% of non-autistic males and 7.8% of non-autistic females without ADHD. These findings underscore that the co-occurrence of ASD and ADHD not only intensifies core behavioural and cognitive challenges, but also significantly increases the risk for mental health concerns. Emerging evidence also indicates children diagnosed with both ASD and ADHD tend to exhibit lower cognitive functioning, more pronounced social impairments, and significant delays in adaptive behaviour, especially in early childhood compared to having a single diagnosis, as reported by a review conducted by Al Ghamdi & AlMusailhi (2024). Parent and teacher reports also consistently reflect greater challenges in daily functioning for these children compared to those with a single diagnosis (Accardo et al., 2024). In addition, in a prospective population-based study conducted by Lebeña et al. (2023) investigating clinical implications of ADHD, ASD, and their co-occurrence in early adulthood found that all three groups had broader psychosocial and

functional challenges. These included concentration difficulties, poorer overall health quality, lower faith in the future, lower perceived control over life, reduced social support, and lower socioeconomic status (Lebeña et al., 2023). The co-occurrence of both was also significantly associated with unemployment, reflecting potential compounded functional impairment and systemic barriers faced by individuals with dual diagnoses.

Despite the growing recognition of co-occurring ASD and ADHD, several gaps in the literature remain. Historically, diagnostic criteria prevented co-diagnosis, meaning many individuals were excluded from earlier research (Al Ghamdi & AlMusailhi, 2024; Davis & Kollins, 2012). In addition, although recent studies have begun to address this issue by studying populations with both diagnoses, much of the existing research has focused on children and adolescents, often using parent or teacher reports to support findings. There remains a significant lack of research examining how this dual presentation affects adults, especially given diagnostic constraints, and such individuals have consequently faced unique challenges. Given that ADHD often presents differently in adulthood compared to childhood, it is essential to develop a clearer understanding of how ASD and ADHD present in adults, particularly through first-hand accounts that reflect lived experience. Indeed, there is still a significant lack of research that conceptualizes how presentations may manifest in adulthood for this population. Existing literature tends to focus either on overlapping symptoms and similarities between the two conditions (Hours et al., 2022; Leitner, 2014), prevalence of co-occurring mental health conditions (Accardo et al., 2024), and challenges in social, emotional, or educational domains (Al Ghamdi & AlMusailhi, 2024), without capturing how co-occurring ASD and ADHD can present uniquely in adults. In particular, much of this research relies on quantitative methods or parent and clinician reports, leaving limited understanding of how adults themselves experience and interpret living with both diagnoses.

Although literature examining co-occurring ASD and ADHD is expanding, very few studies centre the voices of individuals with dual presentations, particularly in adulthood. Craddock (2025) offers one of the first qualitative accounts of the lived experiences of autistic women also diagnosed with ADHD, providing valuable insight into how these presentations shape identity, daily functioning, and access to care. Drawing on semi-structured interviews with ten women, the study explores the complexities of receiving a dual diagnosis and the expectations that may be attached to each diagnosis. Results from this study highlight themes such as ASD and ADHD feeling like both contradictory and complementary forces. Participants also grappled with the tension between medicalised and neurodiversity-based understandings, often describing ASD as intrinsic to who they are, while ADHD felt more external or secondary. Importantly, Craddock's (2025) study does not focus directly on treatment experiences, but rather on diagnostic navigation and identity formation. However, the findings of this study suggest that diagnostic ambiguity and unmet support needs of this population may influence how individuals access or benefit from mental health interventions. The absence of targeted research on how co-occurring autistic and ADHD adults experience psychotherapy or other mental health treatments highlights a critical gap. Thus, further investigation is needed to understand how best to support this population through learning about their experience with mental health care.

ASD and Psychotherapy

As described previously, a substantial proportion of autistic individuals experience co-occurring emotional and behavioural difficulties, as well as an increased risk of mental health challenges and diagnoses. Psychotherapeutic treatment has been shown to be effective in responding to a range of common mental health difficulties among autistic populations, especially when adapted (Cooper et al., 2018). Psychotherapy is not intended to "treat" autism itself, nor should it aim to alter core features of neurodivergence. Rather, it is used to

support individuals on the autism spectrum in managing co-occurring psychological challenges, as well as providing support through the unique challenges this population may face. Although behavioural interventions like Applied Behaviour Analysis (ABA) and occupational therapy may primarily address functional or developmental goals, such as improving executive functioning, fine motor skills, or adaptive behaviours in children and youth (Gitimoghaddam et al., 2022; Stornelli, 2016), psychotherapy predominantly focuses on the emotional and mental health needs of autistic individuals (Rosenau et al., 2024). It is acknowledged of course that mental health along with functional and developmental goals are interconnected and influence each other (Farrow et al., 2024).

Given the high rates of psychiatric co-occurrence among autistic youth and adults, tailored psychotherapeutic approaches can play a vital role in improving quality of life, coping strategies, and overall wellbeing, without pathologizing the individual's neurotype. A range of modalities have demonstrated efficacy in reducing psychological distress among autistic individuals, including cognitive behavioural therapy (CBT) for anxiety and depression (Spain et al., 2015), mindfulness-based interventions for reducing aggression and anxiety (Cachia et al., 2016), acceptance and commitment therapy (ACT) for distress and hyperactivity (Pahnke et al., 2014), exposure and response prevention for obsessive–compulsive behaviours (Kose et al., 2018), and parent-training programmes for conduct concerns (Kasperzack et al., 2020).

In particular, research has focused on adapting CBT, the most commonly studied modality for autistic individuals, among both adults and children (Spain & Happé, 2019), to address co-occurring anxiety, depression, and other emotional challenges. These adaptations are necessary due to core cognitive and communication differences characteristic of autism. A study by Cooper et al. (2018) found that therapists most commonly adapted their practice by using a structured and concrete approach, behavioural strategies, more easily understood

language, and psychoeducation about emotions, as well as integrating visual supports and clients' personal interests when working with both children and adults on the autism spectrum. Less frequently used adaptations included avoiding metaphors, involving family members, and altering session length. The literature thus demonstrated that adapted CBT for autistic individuals has demonstrated moderate to large improvements in efficacy for anxiety (Perihan et al., 2020), emotional dysregulation (Weiss et al., 2018), and depressive symptoms (Gallant et al., 2023).

Although CBT has typically received the most empirical attention, recent findings from a study conducted by Gallant et al. (2023) investigating Canadian clinicians' knowledge, confidence and practices when treating autistic youth and youth with ADHD found that clinicians are also utilizing a broader range of modalities, depending on the presenting concerns of clients. Clinicians reported using several adaptations to address the mental health needs of their clients, and in general, these modifications were found to be similar regardless of if the client had ADHD or ASD. Notably, these adaptations, such as incorporating special interests, using concrete session structure, and providing psychoeducation on emotions, were also seen as useful in supporting youth with ADHD. Although these adaptations can improve therapeutic outcomes, accessing evidence-based psychological treatments remains more difficult for autistic individuals than for the general population. Psychotherapy being social in nature, through meeting a new person, disclosing personal information, and building rapport, can be especially daunting and challenging for this population (Cooper et al., 2018). Additionally, executive functioning differences may affect one's ability to plan, attend, and follow through with therapy appointments and related tasks or homework. Difficulty with emotional processing or identification can also impact therapy engagement and outcomes, especially if interventions do not include directly addressing emotional identification and regulation (Cooper et al., 2018).

Given that psychotherapy is inherently relational, the quality of the therapeutic alliance may be particularly significant for autistic individuals as well. Across the broader psychotherapy literature, alliance has consistently emerged as one of the strongest factors in predicting treatment outcomes and producing the benefits of psychotherapy, as opposed to specific techniques or modalities (Wampold, 2015). In autism-specific research, stronger therapeutic alliance has been associated with better treatment outcomes (Brewe et al., 2021) through improved emotion regulation among autistic adolescents and adults, as well as better treatment outcomes for CBT for anxiety in this population (Kerns et al., 2018). These findings suggest that rapport and relational engagement may function as a key mechanism of change within adapted psychotherapeutic interventions for this population, beyond modality-specific strategies.

ADHD and Psychotherapy

Although ADHD is often associated with childhood, it persists into adulthood as well, manifesting as challenges with attention, impulse control, emotional regulation, and executive functioning, as explained previously. Current clinical guidelines emphasize that treatment recommendations vary by developmental stage. For children and adolescents, the American Academy of Pediatrics (2019) clinical practice guidelines emphasize age-specific, multimodal interventions, including behavioural therapy as a first-line treatment for preschool-aged children and a combination of pharmacological and behavioural interventions for school-aged children and adolescents. Conversely, treatment for core symptoms of ADHD in adolescence and adulthood is primarily pharmacological (Wolraich et al., 2019), typically involving stimulant medications such as amphetamine and methylphenidate, and nonstimulants such as atomoxetine (Liu et al., 2023). However, research shows that these benefits are short-term, and discontinuing ADHD medication often leads to a recurrence of inattention, hyperactivity/impulsivity, and declines in executive functioning (Liu et al., 2023).

Additionally, stimulant medications alone are often insufficient in addressing the psychological and mental health difficulties that frequently co-occur with ADHD (Biederman et al., 2006). Consistent with a multidisciplinary approach, the UK National Institute for Health and Care Excellence (NICE, 2018) recommends combining medication with structured psychosocial interventions when symptoms continue to cause impairment in adults with ADHD. These interventions, such as CBT, should be part of a holistic plan that addresses psychological, behavioural, and occupational or educational needs (NICE, 2018). Furthermore, clinical evidence also supports this combined approach. For example, a meta-analysis of six randomized controlled trials found that CBT combined with medication improved ADHD symptoms more than medication alone among adults, with benefits persisting for up to three months, after which continued or intensified CBT was suggested to maintain gains (Li et al., 2024). Supporting these findings, a smaller study of 54 adults with ADHD conducted by Emilsson et al. (2011) found that adding psychotherapy to medication improved ADHD symptoms and antisocial behavior by the end of treatment. Further improvements in other areas such as depression, anxiety, and social functioning were also seen at a three-month follow-up (Emilsson et al., 2011). Together, these studies highlight that combining pharmacological and psychotherapeutic approaches not only enhances ADHD symptom management, but also addresses associated mental health challenges.

Similar to its functions for ASD, psychotherapy for those with ADHD does not aim to "cure" the condition, but instead seeks to help with associated mental health challenges, with goals such as managing psychological stressors and improving adaptive functioning. Additionally, psychotherapy for ADHD aims to support individuals in managing the impact of ADHD symptoms on both internal experiences (e.g., emotion regulation and cognitive processes) and external functioning across everyday life contexts (Cortese et al., 2025). Within the broader psychotherapeutic landscape, CBT is the most extensively studied and

widely applied psychotherapeutic approach for ADHD among adults, followed by family therapy, solution-focused therapy, and Dialectical Behaviour Therapy (DBT) (Gallant et al., 2023; Liu et al., 2023).

CBT may address both core symptoms of ADHD as well as emotional difficulties by helping individuals develop adaptive thought patterns, improve executive functioning, and learn coping strategies (Lopez et al., 2018). Within CBT, behavioural components often focus on developing practical coping strategies and executive functioning skills, such as organization, time management, planning, and problem-solving, to reduce functional impairments across domains including work, relationships, and daily living (Cortese et al., 2025). Cognitive techniques further target maladaptive beliefs that may be shaped by repeated experiences of negative feedback and internalization (Cortese et al., 2025), which may negatively impact self-esteem, motivation, and hope in adults with ADHD (Ramsay, 2021). CBT has been shown to be efficacious in reducing core ADHD symptoms and improving anxiety, depression, and self-esteem, challenges that are frequently reported by adults with ADHD (Liu et al., 2023). Additionally, third-wave CBT approaches, including DBT and mindfulness-based interventions, have been increasingly applied in the treatment of adult ADHD. These approaches aim to enhance present-moment awareness, emotional regulation, and self-acceptance, which may support self-regulation and reduce ADHD-related distress (Mitchell et al., 2017; Halmøy et al., 2022). Moreover, group-based CBT has been demonstrated to be as effective as individual therapy, with added benefits such as peer support and cost-effectiveness (Liu et al., 2023).

Adaptations to the structure of psychotherapy for ADHD has also been researched in order to suit the unique cognitive and emotional profiles of this population. Several core principles emerged across the literature, with emphasis on the importance of supporting executive functioning through concrete and skills-based approaches (Lauder et al., 2022;

Ramsay & Rostain, 2005). These adaptations include scaffolding tasks, using visual prompts, and breaking down goals to reduce overwhelm and improve task follow-through (Lopez et al., 2018). Psychoeducation is another critical component of successful ADHD interventions, as more than simply informing clients about ADHD, this piece helps to reframe long-held beliefs shaped by stigma or misunderstanding (Lauder et al., 2022). Psychoeducation allows those with ADHD to have enhanced self-awareness and understanding, which in turn supports self-esteem and self-efficacy (Emilsson et al., 2011). Moreover, interventions that are client-led and those involving a significant other have also been found to be more effective, as they foster autonomy and expand social support (Lauder et al., 2022). Furthermore, among individuals with ADHD, a strong alliance, typically characterized by a collaborative and trusting relationship between therapist and client has also been shown to improve treatment engagement, adherence, and overall effectiveness (Flückiger et al., 2018). These findings suggest that rapport and collaboration may be particularly important when working with clients with ADHD.

Co-occurring ASD and ADHD and Psychotherapy

Research has shown that a primary treatment for adult ADHD, typically stimulant medications, seems to be less effective for those who also have ASD, compared to those who have only ADHD (Al Ghamdi & AlMusailhi, 2024). Further supporting this result, in a review conducted by Davis and Kollins (2012), it was highlighted that individuals with co-occurring ASD and ADHD are more likely to experience adverse effects from stimulant medications, including irritability and self-injury, and benefit less from standard doses of medication than individuals with ADHD only. Conversely, behavioural interventions have been demonstrated as being efficacious for ASD management, however, these treatments may not be efficacious in addressing adult ADHD symptoms (Davis & Kollins, 2012). Traditional behavioural interventions designed for ASD typically target social

communication and repetitive behaviours, while those developed for ADHD focus on impulsivity, inattention, and parent-mediated behaviour management, both typically for implementation in childhood (Davis & Kollins, 2012). The authors of this review highlight the notable gap in research examining psychosocial interventions for co-occurring ASD and ADHD, particularly for adults. The relative scarcity of research on adult-focused and dual-diagnosis interventions underlines the urgent need for a greater understanding on therapeutic models in particular, to address the compounding mental health challenges and heightened overall difficulties faced by this population.

Clinicians have stated that interventions such as psychoeducation, parent training, behaviour therapy, and CBT have been helpful for children and youth with co-occurring ASD and ADHD. Indeed, Young et al. (2020) conducted a study by convening a national expert consensus meeting of clinicians in the United Kingdom to address the diagnostic and treatment complexities of co-occurring ASD and ADHD. The panel produced clinical recommendations, emphasizing the importance of multifaceted assessment protocols, individualized care plans, and adapted psychotherapeutic interventions with respect to pre-existing interventions such as CBT, psychoeducation, and parent training. CBT, when adapted can be used to address emotional regulation, anxiety, and low self-esteem in adolescents and adults with dual diagnoses (Young et al., 2020). Adaptation strategies included increasing the use of visual and written materials, simplifying language, providing clear structure and rules, incorporating special interests, involving caregivers, and placing more emphasis on behavioural than cognitive strategies (Young et al., 2020). Psychoeducation fosters understanding, coping, and advocacy by providing both individuals and families with accurate, tailored information about both conditions (Young et al., 2020). Moreover, parent training allows caregivers to be equipped with strategies to manage both behavioural challenges and social-communication difficulties among their children. While

this study comprehensively examines treatment perspectives from clinicians, a gap in the literature is the lack of quantitative data on the actual efficacy of these interventions for individuals with both ASD and ADHD, as well as the lack of adult-focused and qualitative research on intervention effectiveness from the perspective of those with lived experience. Similarly, mindfulness-based approaches have demonstrated potential in addressing anger and anxiety (Singh et al., 2011), and narrative therapy has shown promise in promoting social adaptation and self-esteem in youth with either ASD or ADHD (Gallant et al., 2023). However, these interventions have not yet been systematically studied in adults with co-occurring ASD and ADHD. This gap highlights the potential for adapting existing psychotherapeutic modalities, such as mindfulness and narrative therapy, to meet the unique needs of this dual-diagnosis population. Systematic evidence examining these interventions and exploration of other psychotherapeutic modalities remains limited.

Gallant et al. (2023) also found that clinicians reported significantly lower self-rated knowledge and confidence when providing psychotherapy to autistic youth compared with youth with ADHD, across multiple domains of therapeutic practice. Specifically, clinicians felt less knowledgeable about core symptoms, treatment planning, and implementing interventions for autistic clients, and reported lower confidence in therapeutic activities such as communication, developing rapport, and selecting effective approaches for autistic clients (Gallant et al., 2023). Furthermore, Roudbarani et al. (2023) explored clinician factors when providing psychotherapy to autistic youth and youth with ADHD in Ontario, Canada, and similarly found that clinicians were less likely to treat autistic clients than clients with ADHD. This finding was attributed to factors such as differences in attitudes, such as perceived advantages or disadvantages of starting treatment, social pressures, and lack of knowledge. Thus, given that clinicians experience reduced confidence and perceived competence when working with autistic clients alone, it is reasonable to extrapolate that these

challenges may be further compounded when treating adults with co-occurring ASD and ADHD, due to the increased complexity of dual presentations. As such, this potential barrier underscores the need for further research on psychotherapeutic approaches for this population to help improve clinical approaches and outcomes.

Neurodiversity, Positive Psychology and Sources of Resilience

There is also a need to examine positive psychology approaches to neurodiversity, such as better understanding resilience and strengths of individuals with both ASD and ADHD. Although it has been discussed that individuals with ASD and ADHD experience challenges, many of these are exacerbated from navigating a world designed around neurotypical norms (Swanepoel, 2024). Thus, it is also vital to emphasize the importance of the neurodiversity movement, which has only emerged in recent decades (VanDaalen et al., 2025). The concept of neurodiversity highlights neurological differences among humans as natural and valuable variations of cognition, as brain and mind development can have differences both structurally and functionally (Pellicano & den Houting, 2022). Although traditional medical models and the DSM-5-TR definition of autism or ADHD often view neurodevelopmental differences through a deficit lens, modern approaches emphasize neurocognitive diversity as a source of unique strengths, abilities, and perspectives (Kapp et al., 2013).

For many individuals, having autism, ADHD, or both can also be an important part of their identity and how they understand both themselves and the world (Swanepoel, 2024; Young et al., 2020). These neurodevelopmental differences are not only characteristics to be managed but also aspects that shape personal experiences, perspectives, and ways of interacting with the world. This understanding is supported by empirical research, as Kapp et al. (2013) examined conceptions of autism and neurodiversity using an online survey of autistic individuals, relatives and friends of autistic people, and individuals with no specified

relation to autism (N = 657). They found that self-identification as autistic and greater awareness of the neurodiversity movement were both factors associated with viewing autism as a positive identity that does not need to be cured. At the same time, participants across groups similarly acknowledged that autism can involve difficulties, and they supported approaches that focus on helping with challenges than attempting to change or reduce core aspects of autism. As such, language preferences, such as whether someone uses person-first ("person with autism") or identity-first ("autistic person") terminology, can also reflect personal choice and how an individual relates to their neurodivergence. Thus, these findings support a "deficit-as-difference" conception of autism among participants (Kapp et al., 2013), in which both strengths and challenges are recognized together.

In particular, it would follow that it is important for clinicians to have a foundational awareness of neurodiversity, so that they can better understand, support, and tailor psychotherapeutic care to neurodiverse individuals (Gallant et al., 2023). Recognizing how neurodiverse individuals experience the world, both cognitively and emotionally, as well as acknowledging their unique strengths and abilities is essential for contextualising interventions that support meaningful change and resilience. The neurodiversity paradigm challenges the medical model of ASD and ADHD, which typically highlights dysfunction and impairment. This perspective aligns with the growing movement toward strengths-based and positive psychology frameworks, which have gained traction in addressing the needs of neurodiverse populations (Pellicano & den Houting, 2022). Positive psychology, with its core emphasis on flourishing, thriving, strengths, and resilience, aligns naturally with the neurodiversity framework (Shmulsky & Gobbo, 2024). In addition, previous research in neurotypical populations suggests that strengths-focused interventions and motivations increase well-being, particularly by enhancing feelings of self-worth, which in turn induces positive affect and self-esteem (Taylor et al., 2023).

In addition, Doyle (2020) outlined the unique strengths of individuals with ADHD and autism based on the British Psychological Society's 2017 report on Psychology at Work. It was found that individuals with ADHD typically have strengths in areas such as creative thinking, visual-spatial reasoning ability, hyperfocus, passion, and courage. Comparatively, people with ASD typically have strengths in areas such as memory ability and other 'specialist individual skills', such as reading, drawing, music, and computation, as well as innovative thinking and observation of details. Taylor et al. (2023) also investigated autistic strengths, knowledge, and outcomes through comparing large samples of autistic and non-autistic adults. Their results showed that autistic and non-autistic individuals identified similar personal strengths. However, those with ASD reported less awareness and use of their strengths. Crucially, autistic individuals who reported greater use of their strengths reported greater well-being, a better quality of life, as well as improved mental health through lower levels of anxiety, depression, and stress. These findings suggest that encouraging more strengths use could serve as a meaningful avenue to enhance well-being in autistic populations.

In the context of ADHD, Climie and Mastoras (2015) also argue for the necessity of using a strengths-based lens, particularly within educational environments where those with ADHD are often misunderstood. Cognitive assets among those with ADHD such as creativity, curiosity, and high energy, which are often overlooked in traditional classroom models, are emphasized. When such traits are identified and fostered, children with ADHD can develop greater resilience and enhanced positive self-perceptions, thus combatting the negative consequences of repeated failure or stigma (Climie & Mastoras, 2015). Furthermore, among neurodiverse populations, a scoping review of 176 articles by Black et al. (2024) on sources of resilience showed that the importance of support systems through family and friends, community participation and acceptance, and individual capabilities for resilience

were emphasized. Knowing such factors and hearing lived experiences of neurodiverse individuals can help inform treatment approaches and outcomes. Shmulsky and Gobbo (2024) also found that neurodivergent college students, including those with ADHD and ASD, responded well to classroom-based positive psychology exercises. These practices included activities relating to acts of kindness, gratitude, finding and using strengths, and cultivating gratitude. Students reported positive impacts, including improved well-being, feeling stress-free and calm, and experiencing positive mood boosts.

In addition to the research pertaining to neurodiversity and positive psychology, emerging qualitative research has begun to examine neurodivergent individuals' lived experiences with counselling and psychotherapy. For instance, one recent qualitative study examining neurodivergent individuals' lived experiences in counselling identified themes such as; frustration and confusion regarding language used in counselling, clarity and validation in language, overwhelm related to uncertainty and masking, feeling understood and being able to self-advocate, the need for safe sensory environments and accommodations, and broader concerns related to accessibility and practicalities (Jones et al., 2025). These findings suggest that neurodiversity-informed counselling requires more than a shift in conceptual framing, but rather involves practical adaptations in domains of communication and environment, as well as relationally. Importantly, this study and others focus on neurodiverse individuals more broadly, leaving limited exploration of how these considerations apply to adults with co-occurring ASD and ADHD.

Despite the growing body of research focusing on either ASD or ADHD individually or neurodiversity broadly, there remains a considerable lack of empirical work exploring how therapy is experienced in individuals with co-occurring ASD and ADHD. While studies have begun to examine therapeutic processes and outcomes within autism-only or ADHD-only populations, the lived experiences of individuals navigating both neurodevelopmental profiles

remain underexplored. Given the high rates of co-occurrence and the ways in which autistic and ADHD traits may interact in complex ways, further qualitative research is warranted. This absence in the literature is particularly notable in light of emerging research emphasizing neurodivergent identity, resilience, and the importance of moving beyond deficit-based models, toward approaches that recognize both support needs and inherent strengths (Kapp et al., 2013). Furthermore, researchers have called for hearing the firsthand views of neurodiverse individuals on their experiences with psychotherapy (Spain & Happé, 2019), highlighting the need for studies that uplift lived experiences, alongside strengths-informed practice.

Current Study

Although there has been one existing qualitative study exploring the lived experiences of adults with both autism and ADHD, no study to date has specifically examined experiences of psychotherapy among this population. As previously discussed, this is a population with distinct clinical profiles, treatment challenges, and support needs. There is also a general lack of research focused on adults, aged 18 and above, with both conditions, despite growing recognition of their unique developmental and psychosocial concerns. The current study addresses these gaps by exploring the lived experiences of psychotherapy among adults with co-occurring ASD and ADHD. This demographic was also intentionally selected based on literature suggesting psychotherapy to be more suitable for older adolescents and adults with both ASD and ADHD, rather than children with both ASD and ADHD, given their increased cognitive, verbal, emotional, and reflective capacities. (Young et al., 2020). By focusing on adults, this study aims to capture perspectives that are often overlooked in child-focused research.

This study aimed to capture how adults with co-occurring ASD and ADHD perceive therapeutic effectiveness, barriers, unmet needs, and sources of resilience. This study is

guided by an overarching question: how do adults with co-occurring ASD and ADHD experience psychotherapy? To explore this question, this research examined how individuals interpret effectiveness and relational dynamics in therapy, as well as the barriers and challenges they may face throughout the process. Additionally, informed by a neurodiversity-affirming and positive psychology approach, the study also seeks to understand the strengths and forms of resilience that participants draw on. Together, these inquiries aim to deepen understanding of how adults with co-occurring ASD and ADHD engage with psychotherapy, with the goal of informing more accessible and responsive therapeutic practices in the future. In doing so, the study will offer preliminary insights into therapeutic experiences and how interventions can be adapted to better address their complex needs.

The framework of Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) was used to analyze the data. This methodology is particularly well-suited for this study, considering the unique sample of adults with co-occurring ASD and ADHD. Individuals with dual diagnoses often experience psychotherapy in highly individualized ways, due to unique cognitive, emotional, and social profiles, while also sharing common challenges such as symptoms and difficulties, as described previously. As such, this framework allowed for in-depth exploration of lived experiences and how each individual in the study makes sense of their own experiences.

No study has explored the impact of psychotherapy for this population through the first-hand perspectives of those with lived experiences. By focusing on the voices of adults with co-occurring ASD and ADHD, this study aims to uplift and prioritize perspectives that remain underrepresented in clinical research. In doing so, the study recognizes individuals as experts of their own experiences and seeks to create a more inclusive understanding of psychotherapy that reflects the realities of those directly engaged with it.

Methods

Recruitment

Research Ethics Board approval was obtained by Saint Paul University. Financial support for the study was awarded by Saint Paul University through the Graduate Student Support Program. Participants were recruited through a combination of methods to ensure broad reach and inclusion of diverse perspectives. Recruitment methods included social media postings, community outreach, snowball sampling, and general word of mouth. Community outreach and word of mouth included poster advertisements in community locations, universities, clinic offices, universities, newsletters, the Attention, Behaviour, and Compassion (ABC) Lab, as well as through therapist networks. All recruitment materials provided a description of the study, inclusion/exclusion criteria, honourarium details, as well as instructions for contacting the Principal Investigator through the ABC Lab at Saint Paul University, to express interest in participation.

Inclusion and Exclusion Criteria

Participants were eligible to take part in the study if they were 18 years of age or older, residing in Canada, had either a clinical or a self-identified/suspected diagnosis of both Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) as well as access to internet and Zoom (Zoom Video Communications, 2026). Residency in Canada was a requirement, as the study is situated within the Canadian healthcare and psychotherapy context. Participants were also required to have either participated in psychotherapy in the past or currently, as the study aimed to explore lived experiences within therapeutic contexts. Fluency in English was a requirement for inclusion as all study materials, including the screening questionnaires and semi-structured interviews, were conducted in English. Given the barriers to receiving diagnoses and assessment previously discussed, self-reported identification was accepted (Kroll et al., 2024), in addition to formal

diagnoses, as part of the inclusion criterion. This decision aligns with emerging research practices that acknowledge difficulties with diagnostic accessibility, as well as disparities in the healthcare system (Newton et al., 2025, Malik-Soni et al., 2022). Nevertheless, individuals were asked to provide clarifying contextual information, such as the age of diagnosis or diagnoses, and the type of diagnosing professional, or the age of self-identification and how this came to be. This information was collected to contextualize participant heterogeneity during data analysis.

Participants were excluded from the study if they were under 18 years of age, not fluent in English, or had never accessed psychotherapy services. Individuals who did not report having either formal or self-identified/suspected diagnoses of both Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) were also ineligible. Additionally, participants with medical or psychiatric conditions that would significantly interfere with participation, or for whom participation posed a potential health risk, were not eligible. All participants were required to provide informed consent, and individuals who did not provide consent were not eligible for the study.

Participants

A total of five adults who reported having either clinically confirmed or self-identified diagnoses of both Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) participated in this study. Participant ages ranged from 23 to 52 years. All participants identified as Caucasian and resided in Ontario or Quebec, Canada. Four participants identified as female and one identified as male. With respect to education, two participants reported having completed a Master's degree, two reported holding a Bachelor's degree, and one reported completing a high school diploma. Four of the five participants were currently enrolled in university studies. Occupational status varied, with participants identifying as students, employed full-time, employed part-time while studying, or employed

full-time while also enrolled in academic studies. In regards to marital status, one participant identified as single, two were married or in a domestic partnership, and two were divorced. Other mental health diagnoses and challenges that participants reported include: generalized anxiety disorder (GAD), depression, anxiety-related concerns and complex post-traumatic stress disorder (cPTSD). Three participants reported experiencing anxiety, two reported depression, and two reported complex post-traumatic stress disorder (cPTSD). Therapy providers included psychiatrists, psychologists, psychotherapists and social workers.

Participant A.

Participant A was diagnosed with both ASD and ADHD in childhood. He described growing up feeling different and confused, particularly in school and social settings prior to learning about his diagnoses. Upon learning about the diagnoses, he described a sense of understanding and clarity. He attended individual therapy at two points in his life, and rated his overall experience with therapy as a five out of seven in effectiveness (mostly effective). As a child, he engaged in weekly therapy for approximately two years with a psychologist, in the context of his parents' divorce. In adulthood, he returned to therapy during a period of heightened academic stress and mental health challenges while completing his university degree. At that time, he described feeling unable to continue his studies and not fully equipped to manage the challenges associated with his ADHD and autism. He accessed therapy services through his university, approximately twice per month over four months. He noted that the limited number of sessions provided by the university meant that the support felt helpful in the moment, though it did not extend beyond that period. He also reported having academic or workplace accommodations in place.

Participant B.

Participant B has a formal diagnosis of ADHD and self-identifies with ASD. She first began to question whether she might be autistic in early adulthood, during a period when

maintaining masking became more difficult, and certain traits became more noticeable. This realization was emotional and involved a period of self-discovery and she pursued formal assessment. She received a formal diagnosis of ADHD following assessment, and she described feeling confused and resistant to that diagnosis at first, questioning whether it accurately reflected her experience. Over time, she described that the combination of both ASD and ADHD felt most reflective of her experience and provided her with understanding of herself. She is also currently still awaiting further confirmation of an ASD diagnosis due to delays in the diagnostic process.

She engaged in therapy twice in adulthood, and rated her overall experience of therapeutic effectiveness as a four out of seven (moderately effective), particularly in relation to emotion regulation and interpersonal relationships, struggles with identity, work-life balance as well as symptom management. Her first therapy experience was for approximately eight to nine sessions with a social worker, during which Eye Movement Desensitization and Reprocessing (EMDR; Shapiro, 1989) therapy was also used to address intense emotional experiences. She discontinued therapy and did not return for approximately two years. Following her formal ADHD diagnosis, she revisited therapy and discussed engaging in a primarily talk-based, cognitive-behavioural therapy approach. She also reported having academic or workplace accommodations in place and having coaching or skills training (e.g., executive functioning, life skills) within therapy.

Participant C.

Participant C was formally diagnosed with both ASD and ADHD in adulthood. She reported having an internal sense for many years that autism and ADHD were likely relevant to her experience, though she did not receive a formal diagnosis until later in adulthood. Prior to receiving her diagnoses, she described being given other mental health labels that did not feel accurate. She eventually received formal diagnoses of both ASD and ADHD at the same

time. She noted that the financial cost of formal assessment had been a significant barrier to obtaining an earlier diagnosis. She described receiving the diagnoses as bringing relief and providing a sense of self-understanding. At the same time, she expressed a sense of sadness when learning about her diagnoses, due to having spent many years struggling without clarity and appropriate support.

Participant C described engaging with mental health services across multiple stages of her life in both childhood and adulthood, including individual therapy, group therapy, art therapy, residential programs, spiritual counselling, and equine therapy. She rated her overall experience of therapeutic effectiveness as a four out of seven (moderately effective). She noted that much of this support was accessed during periods of difficulty and tended to be short-term or program-based in nature at different points in her life depending on her circumstances. She later established a longer-term therapeutic relationship with her current therapist for concerns related to depression, anxiety, trauma-related difficulties as well as for autism and ADHD. She also reported having engaged in family or couples therapy, coaching or skills training, complementary or alternative treatments, special diets or supplements, as well as academic or workplace accommodations in the past.

Participant D.

Participant D self-identifies with both ASD and ADHD. She recognized traits associated with ADHD and autism after her daughter was formally diagnosed in elementary school. In learning more about neurodevelopmental conditions, she described resonating with aspects of both ADHD and autism in her own experience and reflecting on her own childhood. She expressed ongoing interest in obtaining greater diagnostic clarity, noting that the financial cost of formal assessment remains a barrier. Her counselling history spans many years and involved multiple services across different contexts, from community counselling services. She engaged in couples counselling and later joined a domestic violence counselling

group, as well as engaged in parenting-related services. She also attended individual counselling after these experiences for a short amount of time. She described her experience as a patchwork of counselling, involving different providers for different needs, and her overall experience of therapeutic effectiveness rated at a five out of seven (mostly effective). She also reported having engaged in family or couples therapy and group therapy in the past.

Participant E.

Participant E was formally diagnosed with both ASD and ADHD in adulthood. Participant E reported first receiving an ADHD diagnosis in childhood after being described as a highly hyperactive child. Later in adulthood, following her children's diagnoses, she sought further assessment herself and received diagnoses of both autism and ADHD. She described her children's diagnoses as a significant prompting factor in pursuing her own reassessment. Upon receiving her autism diagnosis, she noted that it was not a major shock but helped her better understand herself, particularly making sense of longstanding experiences of feeling different.

Participant E reported having engaged in therapy in childhood, as well as at a few different times in adulthood, with her overall experience of therapeutic effectiveness rated at a five out of seven (mostly effective). She re-engaged in psychotherapy later into adulthood, initially motivated by a desire for greater self-understanding and personal growth. Over time, she worked with different therapists and transitioned to a practitioner whose scope better matched her needs. She has been in a sustained therapeutic relationship with her current therapist for approximately a decade and described this period as involving significant personal development. She also reported having engaged in family or couples therapy, coaching or skills training, complementary or alternative treatments, special diets or supplements, as well as academic or workplace accommodations in the past.

Procedure

Upon contacting the research team at Saint Paul University, participants completed an online eligibility screening questionnaire to determine whether they met the study's inclusion and exclusion criteria. Eligible participants were then provided with an informed consent form to review and electronically sign before proceeding to the study activities. Upon giving their consent, participants were asked to complete an online demographics and mental health history questionnaire through the Qualtrics survey platform, to complete prior to the interview. Participants were also scheduled for a semi-structured individual interview, lasting approximately 60 minutes. All interviews were conducted through Zoom (Zoom Video Communications, 2026), using a secure University of Ottawa institutional account. With participant consent, all interviews were recorded and transcribed for analysis using the Zoom audio transcription software. Participants were also informed that they would be contacted via email with a brief summary of the study findings upon completion of the research. Upon completion of the interview, participants received a $20 CAD electronic gift card in recognition of their time and contribution.

Measures

Demographics and Mental Health History Questionnaire

A self-report demographic and mental health history questionnaire were administered to each participant through an online Qualtrics survey platform (Qualtrics, 2026) prior to the interview, to gather background information and contextualize participants' psychotherapy experiences. The questionnaire was divided into three parts, demographic information, diagnostic and mental health history, and treatment or therapy history. This information was collected to characterize the participant sample and aid in providing context for interpreting qualitative results. The demographics section collected information on general demographics such as age, ethnicity, gender identity, education, employment status, country of residence, primary language and household income. In the next section, participants were asked to

report whether they had received a formal diagnosis or self-identified/suspected diagnosis of ASD and ADHD, as well as the age at diagnosis or self-identification for each condition. Additional questions assessed participants' past and current experiences with mental health, developmental, neurological, or learning disorders. This section also explored participants' engagement with mental health services, including whether they had previously or were currently seeing a mental health professional, the frequency of sessions, and the primary reason for seeking support. Participants were further asked about past and current use of psychiatric or mental health-related medications, including the type of medication, duration of use, reason for prescription, and perceived effectiveness, rated on a seven-point Likert scale, ranging from very ineffective (one) to very effective (seven).

The final section assessed participants' experiences with a range of therapeutic and support-based interventions. Participants indicated whether they had ever engaged in various forms of treatment, including individual psychotherapy, group therapy, family or couples therapy, occupational therapy, Applied Behaviour Analysis (ABA), coaching or skills training, neurofeedback or biofeedback, complementary or alternative treatments, special diets or supplements, and academic or workplace accommodations. Participants rated the perceived effectiveness of each intervention on a seven-point Likert scale. Additionally, an open-ended option was included for participants to include any additional treatments not listed.

Qualitative Interviews

A semi-structured qualitative interview was used to collect detailed accounts of participants' lived experiences with psychotherapy and sources of resilience. A semi-structured interview is well-suited to this study due to the balance between consistency across interviews and flexibility to explore unanticipated topics in depth (McGrath et al., 2018). For the population of this study, this format allowed participants with lived experience to share

their experiences in their own words, giving voice to individuals often underrepresented in literature, while maintaining balance between both structure and fluidity with the interview process.

The interview guide was organized around main themes such as background in terms of diagnoses and psychotherapy, positive experiences with psychotherapy, challenges or less helpful experiences with psychotherapy, therapeutic goals and outcomes, sources of resilience, and reflections and suggestions. The interview consisted of a series of open-ended questions designed to address the core research aims, while simultaneously enabling participants to elaborate on areas of personal significance. Probing and follow-up questions were employed to clarify meaning, explore nuances, and gather detail on aspects such as the therapeutic alliance, types of therapy received, and the perceived impact of specific therapeutic approaches or tools. The interview concluded with a broad, open invitation for participants to share any additional reflections.

Data analysis

All interview audio recordings were transcribed through Zoom's automated transcription software (Zoom Video Communications, 2026) upon completion of each interview. The primary researcher verified the accuracy of each transcript, and identifying details were removed during the transcription process, with participant names replaced with an alphabetical letter instead. All qualitative data was then analyzed using IPA. IPA is a methodology employed in qualitative research that aims to facilitate detailed examinations of lived experience, as well as describe the essence of experiences shared by individuals who have lived the same phenomenon (Smith & Osborn, 2015; Creswell & Creswell, 2018). This approach is particularly valuable for the investigation of experiences that may be unique, nuanced, or ambiguous, as it prioritizes participants' own perceptions and meaning-making, expressed in their own terms (Smith & Osborn, 2015). The methodology of IPA emphasizes

understanding how individuals who have undergone similar experiences make sense of those experiences, rather than organizing data through predefined categories (Alase, 2017; Smith et al., 2009). Additionally, IPA is typically utilized following in-depth engagement with a small number of participants (Creswell & Creswell, 2018). As such, this methodology allows for the identification of shared meaning across participants, while also attending to the unique ways each experience is lived and understood by each person (Creswell & Creswell, 2018).

Data analysis closely followed the recommended analytic steps for IPA (Smith et al., 2009), analyzed using the *NVivo* software (Lumivero, 2025). First, interview transcripts were read and re-read multiple times by the primary researcher to ensure immersion in the data and to develop a comprehensive understanding of each participant's account. During this phase, initial noting was conducted and preliminary interpretative observations were examined. Next, emergent themes were developed from these initial notes through an inductive coding process. These themes were then organized into broader thematic categories within each individual case. Following analysis, connections between themes were also examined across cases in order to identify shared patterns of meaning, while simultaneously taking into account individual differences in participants' lived experiences. Throughout the analytic process, rigour was also maintained through reflexivity, including through the use of ongoing self-reflection and memo-writing. These reflective practices supported awareness of potential assumptions and interpretative positioning within the process, ensuring that the interpretations were grounded in the data and aligned with the core principles of IPA. In addition, analytic discussions with the research supervisor supported reflexive engagement with the data and emerging themes.

Results

Overview

Data analysis resulted in the development of four superordinate themes that represent the overall experiences of adults with both ASD and ADHD regarding therapy and sources of resilience. These themes include: (1) Positive Experiences with Therapy, (2) Negative or Challenging Experiences with Therapy (3) Sources of Resilience, and (4) Participant Recommendations. The superordinate themes each consist of subordinate themes that were developed, reflecting the experiences narrated by participants. In total, 11 subordinate themes were identified (refer to Table 1).

Table 1
Superordinate and Subordinate Themes

Superordinate Themes	Subordinate Themes
Positive Experiences with Therapy	Strong rapport and alliance Increased self-understanding Therapeutic focus on lived experience Tools, resources, and psychoeducation
Negative or Challenging Experiences with Therapy	Invalidation and Feeling Unheard Limited Accommodation of Sensory and Communication Needs Pressure to Conform
Sources of Resilience	Strengths associated with Autism and ADHD Personal and relational sources of resilience
Participant Recommendations	Therapist responsibility and clinical practice Public understanding of neurodiversity

Positive Experiences with Therapy

All five participants described having a range of positive therapy experiences that were experienced as meaningful, supportive, and, in some cases, even having a pivotal role in their lives. These experiences were not tied to a single therapeutic modality, but rather to how therapy was experienced relationally and experientially. For four participants, positive

therapy experiences were described as particularly pivotal, marking a significant shift in how they understood themselves and their experiences. One participant reflected that therapy was "a very positive experience, and I don't think I would be here without that experience, being at the university" (Participant A). Another participant described how therapy allowed her to challenge deeply internalized negative beliefs about herself and her worth, especially within relationships. Reflecting on this shift, Participant E explained:

> If I hadn't been to therapy, I wouldn't have, because how would I know any different? I had spent all of my adult life up until that point without therapy, being in relationships that were abusive in every single way, because that's what I thought was normal. And that's how I thought I was supposed to be treated because if you're bad, then that's what you deserve. So it opened up a whole new world when I found out that it's a lie about myself, yeah. So, life-changing, really.

Overall, therapy was experienced as more than supportive for many participants, representing a meaningful shift in their lives.

Strong Rapport and Alliance

When asked about positive experiences with therapy, all participants highlighted the importance of the therapeutic relationship itself and having a strong rapport and alliance with their therapist. One of the ways rapport and alliance was experienced by participants is through a comforting, validating presence from their therapist, which allowed participants to feel heard, safe, and emotionally supported. Participants described the therapeutic relationship as a space where vulnerability and emotional overwhelm could be expressed safely, with therapists responding in ways that conveyed care and attunement. Participant A described being overwhelmed during a difficult time, and reflected on how their therapist responded with comfort and support: "I remember crying, just out of being overwhelmed from everything, you know, talking about it, and the therapist was fantastic, you know, was

able to kind of comfort me, and to look at things from a different perspective." A strong rapport as a comforting, validating presence was also described in terms of having consistent support during difficult times. Participant D emphasized the importance of therapy as a reliable support system, particularly when personal support felt limited, stating; "having a support system, right? That much of a support system personally, especially after, like, having kids and staying home and working from home. So, yeah, having people to talk to and a support system was very helpful." For others, feeling emotionally supported involved having their experiences validated. Participant C described the relief of having their childhood trauma acknowledged in a way that allowed them to accept their emotional responses: "Hearing from someone that it's okay that you feel that way? I think that was a good experience." Taken together, these experiences indicate that rapport and alliance were closely associated with a comforting and validating presence within the therapeutic relationship.

Another way rapport was experienced was through relational equality and humanness of the therapist, echoed by three out of five participants. Participants described valuing their time in therapy where the therapist was experienced as human, approachable, and non-hierarchical, which fostered trust and openness. For example, Participant C described this as "there's no sense of, like, you know, she's better than me or anything, but just having this conversation as two human beings, and she's really just trying to help me figure it out for myself." Relational equality was also experienced through appropriate therapist self-disclosure, which contributed to a sense of mutuality and connection within the therapeutic relationship, as Participant A described:

> I felt as though that, I got to know her as well, it wasn't just me blathering on about myself. I got to know her as a person, some interests about her, and I felt as though that there wasn't kind of this barrier, or like, you know, she was just the, the

> microphone, or the black box where I just talk at her, it records everything, and then, you know, I can listen back to it, right? There was someone there that I felt as though that I was connected to.

Similarly, Participant C's experience of one of her therapist's self-disclosure, in which she shared that she was autistic as well was noted to be a "game changer, because I was like other therapists are autistic? What? And it was really… That was affirming. Just knowing that other people exist, you know?"

Within the therapeutic context, the safety fostered by a strong therapeutic alliance also allowed participants to reduce masking in certain safe and validating environments. A strong therapeutic alliance created conditions in which participants felt safe enough to reduce masking and present more authentically. Several participants described how feeling safe within the therapeutic relationship allowed them to gradually reduce masking and engage more authentically in the therapy space. For instance, Participant B emphasized the support they received and how that encouraged authenticity; "they [the therapists] were supporters during a really tumultuous time in my life, where I was trying to understand myself, and it's helped me unmask in different ways" Similarly, Participant A discussed this gradual process of unmasking over time as therapist-client rapport and alliance grew stronger, and also potentially highlighting the therapist's ability to create safety in the therapeutic space:

> Because of the techniques that the therapist used to make it feel like I could take down that mask, because the first couple sessions, no. I was very much here, this is my mask, hope you like it. And that was that, but then, again, as time goes on, the mask can slip and slip and slip until finally it's just, here I am.

Taken together, these illustrate that rapport and alliance were a central feature of participants' positive therapy experiences, influencing how support, relational equality, and authenticity were experienced within therapy.

Increased Self-Understanding

Four participants described having positive therapy experiences that supported an increase in self-understanding and self-compassion. In particular, this occurred through gaining clearer insight into their neurodivergent experiences and reducing long-standing patterns of self-blame. These experiences were described as a space where participants were able to make sense of their difficulties in a more compassionate way, allowing for greater acceptance of personal limits and needs. Participant A reflected on how therapeutic support helped him reframe self-criticism and move toward greater self-acceptance, particularly in relation to expectations he held for himself:

> She cut me a lot of slack that I wasn't cutting myself. But I wouldn't…I wasn't going to cut that slack for myself. I felt as though that I needed to just double down, and that maybe it was just the ADHD and the autism in me that just wasn't letting me overcome that, so when she cut me that slack, it felt as though I was like, okay I can sit down and I can accept the fact that, no amount of forcing myself to just work through it was gonna cut it. Something had to change. I can accept the fact that I'm not perfect, and I can now try and take steps to fix that, to accommodate me.

Such shifts in understanding were often described as moving away from internal blame toward greater understanding and compassion for their circumstances among participants. Similarly, Participant B explained how therapy helped her better understand herself, particularly related to Autism and ADHD:

> I've always wanted to be able to kind of understand a little bit more, because for things that I thought, like, maybe I was making a big deal about, or, like, being so inflexible, why am I like this? Helped to kind of understand, like, I've learned that I also have, like sensory sensitivities and big deals, so for things where I'm like, oh, why am I always emotional and overreacting on things? It's because I have sensory needs. That I didn't understand at the time. So it did help kind of explore a little bit

more like that, and how to find tools and tricks to help manage those experiences. This experience illuminates how therapy allowed for the exploration of her sensory needs, contributing to greater understanding of herself and her needs. Together, these accounts indicate that increased self-understanding within therapy supported greater self-compassion, as participants described feeling more able to accept themselves and respond to their needs with understanding rather than self-criticism.

Therapeutic Focus on Lived Experience

Within a broader focus on participants' neurodivergent lived experiences, participants described positive therapy experiences as being shaped by neurodiversity-affirming therapeutic practices. These practices involved therapists openly acknowledging autism and ADHD in non-pathologizing ways, adapting therapy to participants' needs, and affirming neurodivergence as a valid and meaningful way of being, rather than something to be corrected. Participant A described how neurodivergence was addressed directly and without negative framing, allowing therapy to remain centered on his experiences and preferences:

> When it was time to discuss the ADHD, autism, it was blatant, and it was not in, like, a negative context. It was just we're confronting it head-on, no finagling around it, we're gonna talk about it openly, and we will move through it how best you like it, and then anything that comes afterwards is just about you.

For some participants, neurodiversity-affirming practice was experienced. Participant E described how her therapist consistently worked from an implicit understanding of neurodivergence, using this lens to support comfort and self-advocacy:

> She understood even before I got the diagnosis, because I was with her having sessions when I went and I got the diagnosis. She always would say, well, as a neurodivergent person. So she knew. She would say if you are, and I'd go, well, I don't know if I am, because I wasn't getting tested through her. So, it was like she

> knew it and got it before I even did, so it was always there, and always looking through that kind of lens, and how she could make me comfortable, and how I could, be taught to kind of use my voice for what I needed.

Focus on lived experience also included therapists that included accommodations and adaptations for some participants, which allowed for comfort and accessibility. Participant C described how her therapist accommodated her needs through flexibility in the mode of delivery, "her willingness to allow me to do phone therapy…that was very helpful." Such accommodations were experienced as affirming participants' needs rather than positioning them as barriers to therapy.

This focus on lived experience also included strengths use within the therapeutic space, which all participants described as being a beneficial aspect of their therapy experience. Participants described therapy as helpful when therapists drew attention to strengths and capacities that emerged from their lived experiences, particularly during moments of struggle or self-doubt. For instance, Participant B described one of her therapists' approaches as "it did make me feel good and accepted, and that my functioning is a superpower, in a way." For some participants, this involved having their perseverance and effort reflected back during periods of distress. Participant A described feeling understood when considering leaving his academic program, noting that his therapist helped to recognize his efforts and resilience underlying his achievements:

> She put into perspective the fact that I didn't just come here, and I walked in here, I didn't have to work for any of it, I did have to work for it, I had to struggle to get where I am right now, and if I truly didn't belong, then I wouldn't even be here in the first place.

Participant E reflected on how therapy supported a shift in perspective regarding difficult life experiences, "tapping into the resilience that I have, and stuff was huge, you know? Even just

situations that I wouldn't have thought that I was resilient. And I didn't look at it like that." She further described the therapist facilitated recognition of these strengths that she possesses; "so it was like, through her eyes, I was able to be recognize those things." For some participants, strengths were also understood in relation to neurodivergence. Participant E described:

> Something that has been really helpful, is going over my autistic gifts. Because there's such a stigma and a negative around autism, and people hear it, and they don't think, like, what a gift, you know? It's not like that's the automatic go-to, so going over with my therapist about what certain gifts that I do have was really helpful. And that was a really good experience. You know, she was, like, the things that I wouldn't even have thought were connected to autism.

Two participants also described valuing therapeutic approaches that acknowledged the presence of neurodivergent-related challenges without consistently tying these experiences to diagnostic labels. Rather than positioning neurodivergence as a defining feature of the self, therapists were experienced as attending to challenges as they arose in participants' lived experiences, and addressing them when relevant. Participant A described how neurodivergence was acknowledged when needed:

> When it needed to come up, right? When I needed saying, like, you know, the accommodations aren't enough, that's when we would get into, okay, let's talk about the ADHD, let's talk about the autism, let's talk about how to solve problems with it, like writing things down, calendar, reminders, all that stuff, but outside of that, no. It was just me.

This approach was echoed by another participant who described therapy as focusing on lived experiences rather than diagnostic framing. Participant C noted, "what I like about my psychologist is that she does not do labels at all," explaining that sessions emphasized lived

challenges rather than focusing on diagnostic categories. As Participant C further described, "we never really talk about autism or ADHD. Like as a title or anything. Talk about experiences… she'll be like, what is hard about getting to school, for example." This way of working was described as allowing space for identity beyond diagnostic labels, with Participant A describing, "It felt as though that it was something that was, you know, we'll leave it on the shelf here, we'll take it off if we need to, but ultimately, that's not who you are. You are you." Together, these accounts suggest that participants experienced therapy as most supportive when neurodivergence was understood without always using labels, but rather as a relevant contextual factor.

Tools, Resources and Psychoeducation

All five participants described learning practical tools and resources, as well as learning through psychoeducation as helpful aspects of their therapy experiences. Although these tools, resources, and psychoeducation may reflect different concerns and purposes for each participant, overall, they were described as helping foster self-understanding for three participants and being supportive in managing daily challenges for four participants. Participants highlighted how therapy supported them in developing various strategies that could be applied to daily life, particularly in managing overwhelm, organization, and task completion. For instance, two participants described learning to slow down and break tasks into manageable steps to reduce complexity. Participant A noted how this strategy, coupled with visual tools, helped make goals feel more attainable:

> Mostly just to slow down, to take things one step at a time… focusing on what I can get done today rather than what I can get done two years from now. Drawing things out, having a visual representation… it doesn't have to be this big, amorphous thing. I can see it, I can visualize it, I can cross things off and feel like I'm going forward.

Similarly, Participant D emphasized the usefulness of learning strategies that reduced

complexity and supported practical problem-solving. She indicated, “it was positive for reframing, and for thinking about steps I can take, and little things I can do to make the situation better… breaking things down into steps and reducing complexity. That was really helpful.” Participant B also described how psychoeducation and recommended resources from her therapist supported self-exploration and skill development:

> I’d often get recommended books and articles and homework activities… and I would come back and say, well, this is kind of what I’ve learned about myself. I think I have these sensory issues, these are triggers for me, and then that’s kind of how we would go about it.

As such, the use of tools, resources, and psychoeducation emerged as a prominent feature of positive therapy experiences.

Negative and Challenging Experiences Related to Therapy

All five participants discussed having negative and challenging experiences at some point within their therapy journeys. These experiences were described as emotionally impactful and, in some cases, shaped participants’ willingness to engage in future therapy. Unlike positive experiences, which were often linked to relational safety and understanding, challenging experiences were associated with feeling invalidated, misunderstood, or pressured to change in ways that did not align with participants’ needs. For some, these experiences contributed to withdrawal, masking, or reluctance to continue therapy.

Invalidation and Feeling Unheard

Several participants described negative therapy experiences characterized by feelings of invalidation or a sense of not feeling heard within the therapeutic process. Two participants had this experience within the context of childhood therapy. For Participant A, he described a sense of mismatch in which he described feeling as though the therapy was for someone else, “I felt as though that I wasn't being heard very much, or, again, the hearing felt

forced, and it didn't feel like you [the therapist] were there for me". This experience highlights how the absence of feeling genuinely heard within therapy contributed to a sense of disengagement and relational disconnection. Participant E described a related, though distinct, experience of invalidation, as well as misplaced blame being placed on her within childhood therapy. She described, "I was always having, I guess, autistic meltdowns at the time, which I didn't understand. I was overwhelmed, I didn't want to do certain things, I would melt down." Participant C recalled that autism was not frequently recognized or discussed at the time, hence she felt fundamentally misunderstood by her therapist, "it wasn't a good experience, because he really didn't get me or autism. Which was clearly what was going on, as well as ADHD at the time. And I… I felt very shamed. And, like, wounded?" Rather than feeling supported, Participant E described internalizing blame, "I was never validated, and everything was always made to feel like my fault, and I was a bad kid." This showed the deeply painful impacts this experience had on participants' self-narrative, and pushed her away from therapy for long after.

Other participants also described experiences of invalidation and feeling unheard within adult therapy contexts. In particular, Participant B felt invalidated regarding her echolalia in which she involuntarily and automatically repeating words and sounds at times reflecting a mis-attunement and misinterpretation of her neurodiverse traits, even though she had a neurodiverse-informed therapist. Participant B recalled a therapy experience that left her feeling invalidated rather than understood:

> "It was made to feel like a deficit, that, like my traits and my personality was kind of looking at that, was impacting my relationships, because it was seen that, you know, I was attention-seeking, and that maybe I had attachment issues, and know that maybe I make decisions too impulsively. Like, I feel like there was very much a negative lens that made me feel guilty."

Limited Accommodation of Sensory and Communication Needs

Participants described instances where therapeutic spaces and communication styles were not attuned to their sensory and language needs. For some, examples involved the use of abstract language within sessions, placing the burden of interpretation on the client. Participant E shared:

> I felt like I was constantly trying to explain myself and how I feel, with just everything, even little things. Like, sometimes my therapist would use little phrases, or analogies. Went right over my head. I didn't get it. So it was like what do you mean? I'd take it very literally.

Three participants also described limited sensory accommodations, with Participant D noting "I don't think there ever was sensory accommodation." Participant C also described how sensory features such as lighting and noise of the therapeutic environment initially created barriers engaging in therapy, "the lighting, the noise… it was just kind of like an attack on your nervous system. And it was like, how can you have therapy? I could barely focus." However, for this participant, she also highlighted how accommodations such as phone therapy supported continued participation in therapy.

Pressure to Conform

Some participants described experiencing pressure to conform to neurotypical expectations within therapy rather than taking neurodivergent ways of being into account. Participant C reflected on repeated messages from therapists in the past to "just try harder", "you're not trying hard enough" and "apply yourself," sharing:

> That's not the case when you're thinking differently. And if you do get it, it's because you're using so much energy and strength inside to be someone that you're not. That by the time you're done, you are cooked for, like, days, sometimes months. So that kind of behaviour with therapists. I think that's the most harmful one, really. To be honest, trying to force people to be in a mold that isn't for me.

This reflects how misunderstandings of neurodivergence within therapy contributed to participants feeling pressure to meet expectations that did not fit their way of thinking. This also led to feelings of being put into expectations that were not designed with different ways of being or thinking in mind. Participant E described a related experience from childhood therapy, in which her neurodivergent traits, particularly sensory overwhelm, were not recognized or understood. Participant E described being asked why she was "bad" and compared to her sister within therapy. She recalled being encouraged to attend therapy through rewards and described feeling as though she needed to change her behavior in order to be accepted. Within this context, pressure to conform was internalized due to messaging in therapy about needing to change in order to be accepted:

> I was clearly very bad, and so that I needed to do this [therapy], because how else could I get better so that everybody would like me? Because when you're… when you're a little kid, what else do you know? You know? And my sister was good, and I was bad. And I needed to follow whatever they told me to do to behave myself. So that people would like me.

In this account, therapy was experienced as emphasizing behavioral correction, with the expectation that she "behave" in order to be liked. For Participants B and D, this pressure to conform also resulted in masking within therapy. Participant B described withdrawing and having to mask after feeling misunderstood by her therapist: "I just remember kind of putting the mask back on then with her, because now she wasn't understanding how I thought she would." These experiences highlight how therapeutic approaches that prioritize conformity over attunement can contribute to exhaustion, masking, and internalized narratives for neurodivergent clients.

Sources of Resilience

Participants described multiple sources of resilience that supported their well-being

and capacity to navigate challenges. These sources reflected both strengths related to neurodivergent ways of functioning, as well as broader personal strengths, relationships, and supports that were not always explicitly framed through a neurodivergence lens.

Strengths associated with Autism and ADHD

Participants described identifying a range of strengths connected to their neurodivergent ways of functioning. Across accounts, participants described abilities related to organization and planning, creativity, sustained focus, hyperfixation, and the capacity to draw on different cognitive tendencies depending on situational demands. For instance, Participant B shared, “I think of things 10 steps ahead… I usually have, like, four or five hobbies going on at a time, so it helps with creativity.” Similarly, Participant E shared, “thinking outside the box is a strength, being able to do stuff like that, being more creative. I'm really creative.” Some participants also described drawing on different neurodivergent traits depending on context. Participant D explained how shifting between structure and flexibility was experienced as useful across situations: “The routine-based and structured autistic side keeps the maybe disorganized ADHD side in check… and the ADHD side makes me a little bit more flexible.” Both participants A and C also discussed monotrophism or hyperfixation as strengths related to their neurodivergence, “I would say strengths are… well, monotropism is a wonderful thing, because it really allows you to, like, dive deep in a lot of things” (Participant C). Overall, these accounts illustrate how participants described neurodivergent characteristics and associated capacities as personally meaningful and supportive, as understood through their own lived experiences.

Personal and Relational Sources of resilience

In addition to neurodivergence-related strengths, participants identified broader personal and relational sources of resilience that were central to their coping and growth. These included perseverance, self-advocacy, public speaking, organizing events, creativity,

music, spirituality, spending time in nature, and supportive relationships. These strengths were often described as long-standing aspects of the self that supported coping and meaning-making in daily life. Participant C identified her relationship with God as a central and sustaining source of resilience, stating, “My huge source of resilience is my relationship with God… that’s just an undercurrent.” Other participants described becoming more confident in using their voice and asserting their needs as an important personal resource. Together, these accounts illustrate that resilience was experienced as multifaceted, arising from a combination of personal and relational supports that participants carried with them across contexts.

Participant Recommendations

Suggestions for Therapist Responsibility and Clinical Practice

All participants discussed suggestions for therapists working with clients who have both ASD and ADHD. These included: collaborative care, sensory and environmental accommodations, neurodiversity literacy, and non-pathologizing approaches. Firstly, participants emphasized their suggestions of effective therapy for neurodivergent clients being collaborative in nature, rather than making assumptions in therapy based on diagnosis. Participants highlighted the importance of open communication and directly asking clients about their preferences and support needs. As Participant C explained:

> Just actually asking a person what do they need? It can go a really long way, and it might seem silly, but every person is different that's gonna be before you who has the same diagnosis. And not to assume that one person, that you see who has this particular support needs, the other one might not. So ask a person what they need, and if they're not able to express that, then finding alternative ways of communication is also super, super helpful.

Within this collaborative approach, all participants described sensory and environmental

accommodations as beneficial in therapy, through flexibility and care on the therapists' part. These accommodations included the physical environment, providing fidgets, as well as the modifications in the format of therapy in ways that enhance accessibility and comfort. Sensory accommodations were highlighted as particularly significant. Participant E explained:

> Have fidgets! … Make sure the lights are not, like, in the center, where they're bright and terrible and in our eyes, you know? Like a lamp, have, you know, a couch or a chair that, sensory-wise feels okay. Make sure you offer online, because online for a lot of neurodivergent people, so they could be in their own area, in their own home, feel some more comfortable."

In addition to in-room modifications, flexibility in therapy format was described as important. Strict adherence to traditional face-to-face, in-office models was experienced as limiting for some participants, and the flexibility to be able to have options and be able to make choices was deemed valued across participants. Participant C shared, "offering alternative forms of communication. Email, text, video chat, phone therapy is really, really powerful, too." Across participants, these accommodations were seen as meaningful components of therapeutic accessibility and comfort. Sensory and environmental flexibility were experienced as supportive when present, and their absence was noted as a barrier to engagement.

Participants also emphasized neurodiversity-affirming literacy as a responsibility of therapists when working with neurodiverse clients. Rather than relying on clients to explain their experiences repeatedly, therapists were encouraged to actively seek understanding of neurodivergent lived realities and be curious when needed. Participant E suggested:

> For therapists who don't have it, read up on what that's like… try to immerse yourself in the community a little bit to get that experience… Because otherwise, it's expected

> for the client to kind of explain the experience all the time, and that's kind of exhausting… Nor is it our duty to do that.

Relatedly, Participant B described feeling judged by a therapist who positioned herself as neurodiversity-informed, yet misinterpreted an autistic trait as "attention-seeking," leading to withdrawal and masking. Participant B emphasized:

> I think a lot of practitioners, in this society, they want to label themselves as, like, I'm trauma-informed, I'm culturally sensitive, I'm neurodiverse affirming…because you want to be as open and accepting as possible, but there's a difference in saying I don't judge people and being affirming to a certain population.

This point underscores the difference between therapists labeling themselves as affirming, compared to being able to meaningfully support neurodivergent clients. Participant B also discussed the importance of transparency regarding training and continuing education, noting:

> "It would be nice if practitioners actually put the extra trainings and continuing education that they've done… because I'd be more likely to go see someone who says that they're neurodiverse affirming, if I've seen that they've done training."

Lastly, participants emphasized the importance of a non-pathologizing stance within therapy more broadly, as well as especially in relation to neurodivergence. Rather than being approached as problems to be fixed, individuals expressed a preference for therapists who prioritize understanding, acceptance, and growth. Participant A when discussing framing of coping strategies, shared, "not being approached like a problem that needs to be solved…more so, like, hey, how can we feel even better?" Additionally, in relation to neurodiversity, participant B expanded on this, suggesting:

> So, anything that can help with understanding and just maybe some compassion, or, like, even you don't have to necessarily say the right thing, but just, like, sitting in the

> moment with it. That makes like, that would make me feel more seen than trying to offer a solution, because it's an identity thing.

Finally, all five participants discussed the value of having a neurodiverse therapist, either through their own experiences or through wanting this in future therapy experiences, noting the value of lived experience as a point of connection and as a way of feeling understood. Participant D discussed having to explain oneself without the connection of lived experience, "the client has to do all the work of trying to translate their experiences into things that the counselor can then understand." Participant A also noted the value of lived experiences:

> "If you have ADHD and autism, and you yourself are a therapist who has ADHD and autism, then you have that lived experience… having that lived experience… would be… infinitesimally… valuable."

Others described experiences with therapists who were accepting but still "didn't quite get it." Together, these accounts position neurodiversity literacy as both an ethical and relational responsibility, while also highlighting how shared lived experience may reduce the burden of translating oneself.

Public Understanding of Neurodiversity

Participants also shared suggestions regarding broader public understanding of neurodiversity. Across accounts, this included (1) increasing awareness of neurodivergent experiences and accommodations, particularly recognizing the additional burden of self-advocacy, (2) reducing stigma and one-size-fits-all assumptions about autism and ADHD; (3) acknowledging the real challenges neurodivergent individuals face, even when those challenges are not externally visible, and (4) improving access to mental health services. Several participants emphasized that a lack of neurodiversity awareness often results in individuals having to repeatedly explain and justify their needs. When discussing education and other systems, Participant 3 shared, "the person who needs the accommodations… is the

one who constantly has to fight. Constantly has to fight to get them. Who doesn't have the executive functioning to do so a lot of times."

Reducing stigma and stereotypes of autism and ADHD was another prominent concern and suggestion for the public. Participants noted persistent misconceptions and negative connotations attached to diagnoses. As Participant 5 explained, "One autistic person, or one ADHD person, you don't meet them all. We're all just different people… but there's a lot of misinformation, and… a lot of negativity." Others echoed that neurodiversity is frequently pathologized, rather than understood as a natural form of diversity and human variation. Participants also emphasized the importance of recognizing the invisible and effortful nature of neurodivergent experiences. Participant C shared:

> To just bear in mind that very fact. It's really, really hard for people to exist with it, because everything is, I would say, 100 times harder than the person next to them. Even if they look, sound… capable of doing the world around, like, it's still that much harder. So compassion, I think, you know, it's just really difficult. And even if you have friends or families and, you know, you just… It looks like it's easy. Yeah, but you have to mask your whole entire life just to make them think that, so…

These reflections call for greater compassion and nuance in how neurodivergence is understood publicly.

Finally, one participant also highlighted structural accessibility concerns, expressing frustration about limited mental health resources. Participant A discussed, "more funding towards getting more therapists, or in schools, getting more access to any mental health resources, in our high schools, in our elementary schools" This point underscores that public understanding must also translate into material investment and access to care. As such, these insights suggest that improving public understanding of neurodiversity involves not only reducing stigma, but also increasing awareness of support needs, minimizing the burden of

constant self-advocacy, and expanding accessible mental health resources.

Discussion

Overall, the therapy experiences of participants in this study reflect both meaningful benefits and notable challenges, with all five participants describing positive and negative aspects of therapy, sources of resilience, and recommendations for clinical practice and broader public understanding. The findings highlight the nuanced and complex experiences of adults with co-occurring ASD and ADHD in psychotherapy. Consistent with research indicating elevated rates of anxiety, depression, and psychosocial challenges among individuals with dual diagnoses (Accardo et al., 2024; Lebeña et al., 2023), participants described entering therapy with significant emotional and relational burdens, for a variety of reasons.

Positive Experiences with Therapy

Multiple positive experiences emerged for participants, with many being seen as pivotal and meaningful turning points, highlighting the potential for therapy to function as a catalyst for meaningful change where participants felt genuinely understood and supported. Firstly, a strong therapeutic alliance and rapport were consistently described as fundamental to the therapeutic process, particularly when therapists provided a validating, emotionally present stance characterized by relational equality and humanness. Participants described feeling more able to speak openly and explore vulnerability when relational safety was established, which in turn supported movement from self-blame toward greater self-acceptance. This finding aligns with broader psychotherapy literature identifying therapeutic alliance as a significant predictor of treatment outcomes (Wampold, 2015). Although research directly examining therapeutic alliance in psychotherapy for adults with co-occurring ASD and ADHD remains limited, evidence from autism-focused and ADHD-focused psychotherapy studies suggests that stronger alliance is associated with improved

engagement and outcomes (Brewe et al., 2021; Flückiger et al., 2018; Kerns et al., 2018). In this way, for participants, the therapeutic relationship appeared to function as a corrective relational experience, particularly in contrast to participants' prior experiences of being misunderstood, pathologized, or inadequately supported, both in external systems and at times in previous therapy. Taken together, the literature and the present findings suggest that alliance may represent an especially important process factor when working with adults with co-occurring ASD and ADHD, a hypothesis that may warrant further empirical investigation.

In addition to a strong therapeutic alliance and rapport, participants described therapy as helpful when it facilitated an increase in self-understanding. This facilitation often involved reframing long-standing self-criticism and gaining clarity about their identities, sensory needs, executive functioning challenges, and/or emotional responses. Psychoeducation and practical strategies were also described as particularly useful in supporting participants' ability to manage daily challenges outside of session, while also enhancing understanding of their neurodivergence. These findings align with literature emphasizing the value of adaptations within ASD and ADHD interventions, including the use of visual supports, simplified language, and structured strategies (Young et al., 2020). Psychoeducation has similarly been identified as beneficial within autism-specific (Gallant et al., 2023) and ADHD-specific interventions (Lauder et al., 2022). Importantly, participants did not describe tools in isolation as transformative, rather, tools were experienced as most beneficial when delivered within an affirming and responsive therapeutic relationship. Additionally, these findings suggest that therapists working with this population therefore require sufficient knowledge to provide accurate, evidence-based tools and psychoeducation.

Participants also valued when therapy centered lived experience, through open acknowledgment of neurodivergence in non-pathologizing ways, without relying heavily on diagnostic labels and through flexibility in therapeutic delivery. Strengths-based approaches

were described as contributing to improved self-esteem, confidence, and self-worth, both generally and in relation to ASD and ADHD. Strengths-based reflection allowed participants to reinterpret traits that had previously been framed negatively, supporting more balanced self-perceptions. This finding aligns with literature indicating that strengths use among individuals in general, as well as ASD and ADHD separately, is associated with improved well-being and psychological outcomes (Climie & Mastoras, 2015; Taylor et al., 2023). Therapists who addressed neurodivergence openly, while not reducing individuals solely to their diagnosis, were experienced as particularly supportive. One participant's account suggests what could be understood as a more subtle or "behind-the-scenes" approach, in which the therapist's knowledge of neurodivergence appeared embedded within their responsiveness and choice of techniques, rather than explicitly emphasized through diagnostic language. This distinction suggests that affirming practice may be experienced less through overt labeling and more through how safety, pacing, and intervention choices are utilized within sessions. This finding resonates with literature on neurodiversity-affirming care, which emphasizes balancing acknowledgment of support needs with respect for identity and agency (Pellicano & den Houting, 2022).

Negative and Challenging Experiences with Therapy

In contrast to the positive experiences described, participants also recounted therapy encounters characterized by invalidation and feeling unheard, limited accommodation of sensory and communication needs, as well as a pressure to conform within therapy. Feeling invalidated or unheard emerged as particularly impactful. When participants perceived that therapists misunderstood their emotional responses, minimized their experiences, or attributed difficulties to personal deficits rather than contextual or neurodevelopmental factors, engagement and outcomes were both described as strained. In some cases, these experiences even had lasting impacts on participants' self-narrative, leading to withdrawal,

reduced openness, or reluctance to continue therapy. These findings are consistent with literature highlighting the consequences of misattunement in psychotherapy, particularly among neurodivergent individuals who may already have histories of being misunderstood within educational, medical, or familial systems (Kapp et al., 2013; Pellicano & den Houting, 2022).

Notably, Participant B articulated a perceived mismatch between her therapist's stated commitment to neurodiversity-affirming care and how the therapeutic experience did not feel neurodiversity-affirming in practice. While neurodiversity was acknowledged in language, the participant described an absence of truly contextualized understanding in practice, as her autistic traits were misinterpreted. This distinction suggests that neurodiversity-informed care may require more than affirming terminology, it may involve active accommodation, individualized responsiveness, and nuanced understanding of co-occurring neurodevelopmental presentations. Although this perspective was raised by a single participant, it highlights a clinically relevant consideration regarding the depth and implementation of neurodiversity-affirming practice. While there is no consensus as of yet on a formal definition for neurodiversity-affirming practice, recent research has attempted to define neurodiversity-affirming clinical practice, which similarly suggests that affirming care extends beyond knowledge of autism or a general strengths-based stance. In a Delphi study of autistic adults and psychologists, neurodiversity-affirming practice was described as involving ongoing learning, safety to be one's autistic self, flexible communication, authenticity and humility, validation of lived experience, and concrete adjustments in therapeutic approach (Flower et al., 2025). These findings indicate that affirming practice includes both action and more nuanced shifts in relational stance. The present finding therefore illustrates how discrepancies between stated commitment and lived therapeutic experience may negatively impact the therapeutic experience. When affirming principles are

not consistently enacted in practice, clients may experience misattunement, despite clinicians' stated intentions.

Participants also described limited accommodation of sensory and communication needs within therapeutic environments. Sensory aspects of the physical space, use of abstract or metaphorical language, and assumptions about communication styles were experienced as barriers to engagement at times. The emphasis on sensory and environmental adjustments suggests that accessibility within therapy extends beyond communication style, but rather also includes the environment of the therapy space as well. Their accounts indicate that when sensory needs are not considered, therapy may require additional cognitive effort simply to tolerate the environment, potentially limiting engagement, and thus can lead to more negative therapeutic outcomes. This finding is in line with the literature, which indicates that both autistic and ADHD populations commonly experience sensory sensitivities that can affect emotional regulation and engagement in structured settings. Within clinical contexts, sensory sensitivity has been identified as a factor contributing to stress and cognitive load in neurodivergent individuals (Jones, Hamilton & Kargas, 2025), hence the present study further underscores the importance of sensory accommodation as part of accessible therapeutic practice. The present findings suggest that when such adaptations were absent, therapy could become cognitively or emotionally taxing rather than supportive. Furthermore, pressure to conform to neurotypical expectations was another theme described by participants. Rather than fostering growth, these approaches appeared to reinforce existing feelings of inadequacy or exhaustion. This finding reflects broader critiques within neurodiversity literature regarding deficit-based models that prioritize normalization over accommodation (Swanepoel, 2024). Thus, within the therapeutic context, such pressures may unintentionally replicate external systems that individuals with ASD and ADHD already navigate.

Taken together, these findings underscore the importance of reducing invalidation, blame, and pressures to conform within therapy, while intentionally incorporating sensory and communication accommodations, particularly given the negative emotional and relational impacts these experiences had on some participants. Clinician education and training that extends beyond diagnostic awareness to include practical adaptation, contextualized psychoeducation, and nuanced understanding of co-occurring neurodevelopmental presentations is necessary to reduce the burden on neurodiverse individuals. Accessible and ongoing training opportunities for clinicians may also help reduce the gap between neurodiversity-affirming intentions and lived therapeutic experience.

Sources of Resilience

Moreover, participants described resilience as emerging from both neurodivergence-related strengths and broader personal and relational supports. Across accounts, strengths such as creativity, organization and planning, sustained focus, hyperfixation, and the ability to shift between structure and flexibility were described as strengths in relation to both ASD and ADHD. Some participants spoke about monotropism or deep focus as allowing them to engage intensely in areas of interest. These strengths are similar to those outlined by Doyle et al. (2020), as well as reflects broader shifts in the literature away from purely deficit-based models of ASD and ADHD, toward recognition of strengths and identity (Pellicano & den Houting, 2022; Swanepoel, 2024). Research has also suggested that identifying and using personal strengths may support well-being among neurodiverse individuals (Climie & Mastoras, 2015; Taylor et al., 2023), which all participants affirmed in this study. The present findings also illustrate how individuals with co-occurring traits may experience the interaction between these characteristics as both challenging and at times, supportive. In addition to neurodivergent strengths, participants described perseverance, self-advocacy, public speaking, music, spirituality, time in nature, and supportive relationships as important

sources of resilience. Together, these accounts suggest that resilience was not located in one domain alone, but shaped by personal values, relationships, and ways of understanding oneself.

Participant Recommendations

Participants' recommendations for therapist responsibility and clinical practice centered on collaboration, flexibility, and meaningful neurodiversity literacy. Effective therapy was described as grounded in direct inquiry rather than diagnostic assumptions, with participants valuing therapists who asked about individual preferences and support needs. This emphasis on collaboration suggests that participants experienced individualized adaptation as central to feeling understood and respected. Sensory and environmental accommodations were consistently described as shaping comfort and engagement. Adjustments such as lighting, fidgets, and flexible formats were not viewed as add-ons or optional factors, but as practical elements that reduced strain on individuals and helped support meaningful participation in therapy. This finding suggests that when absent, the environment itself could become a barrier.

Participants also distinguished between therapists who identified as neurodiversity-affirming and those who demonstrated applied understanding in practice. One participant described a mismatch between affirming language and lived therapeutic experience, particularly when autistic traits were misinterpreted. While this perspective was raised by a single participant, it highlights an important distinction between terminology and depth of understanding. Across accounts, participants expressed fatigue with repeatedly explaining their experiences, suggesting that neurodiversity literacy involves more than openness or positive intent. Rather, meaningful competence appeared to require contextualized understanding, individualized adaptation, and willingness to engage with lived realities. Importantly, all five participants also noted the perceived value of shared lived experience in

therapy, through having a neurodiverse therapist in reducing the burden of providing constant explanations. Together, these accounts suggest that neurodiversity competence is demonstrated through practice, not just through terminology, and lived experience from the therapist may strengthen alliance by supporting deeper contextual understanding and minimizing the need for repeated self-advocacy.

Participants' reflections further suggest that their therapeutic experiences cannot be separated from the broader social environments in which they live. Their emphasis on public understanding indicates that resilience and well-being are shaped not only by individual coping strategies, but by the degree to which external systems reduce or intensify strain (Swanepoel, 2024). In particular, participants highlighted the ongoing burden of self-advocacy, describing the paradox of having to repeatedly justify support needs, while simultaneously navigating executive functioning challenges. This finding suggests that neurodivergent resilience may be constrained or supported by the overall environment and context in which individuals are in.

Participants also called for reduced stigma and greater recognition of differences in presentations within autism and ADHD. Their frustration with one-size-fits-all assumptions suggests that public narratives may often oversimplify neurodivergent identities, as well as both strengths and challenges. When diagnoses are reduced to stereotypes, individuals may be forced to either conform to narrow expectations or continuously correct misconceptions, and as such, stigma may function as an ongoing relational burden. The invisibility of effort emerged as another critical concern, with participants describing masking and sustained cognitive labor as largely unrecognized by others, suggesting that public misunderstanding can make existing challenges even harder to carry. When effort and masking go unrecognized, individuals may feel unseen, even when no overt discrimination is present. This finding is in line with researchers emphasizing that neurodiversity affirming

interventions should not minimize the challenges that neurodiverse individuals face and clinicians must also be mindful of only using strengths-based language (Lerner et al., 2023). Instead, helping clients to use their strengths even in the face of these challenges is a more balanced and clinically accurate approach (Lerner et al., 2023). Furthermore, participants also emphasized that awareness alone is not enough without accessible mental health services. In their view, reducing stigma must be accompanied by practical supports and increased access to care. These may include supports such as reduced financial barriers, clearer pathways to assessment and care, and an increase in accessible therapy services delivered by clinicians with meaningful neurodiversity training to reduce the ongoing burden of self-advocacy and self-explanations that participants often reported. Together, these reflections indicate that improving public understanding involves both greater compassion and more tangible structural support.

Implications and Future Directions

The findings of this study have several implications for clinical practice and future research. First, the results suggest that effective psychotherapy for adults with co-occurring ASD and ADHD may require greater emphasis on individualized adaptation and explicit collaboration. Rather than relying solely on diagnostic knowledge, clinicians may benefit from routinely incorporating direct inquiry into clients' sensory preferences, communication styles, and executive functioning needs. This approach may help reduce assumptions and foster greater relational safety. Second, the consistent emphasis on sensory and environmental considerations suggests that accessibility should be viewed as a core component of therapeutic practice. Training programs and continuing education initiatives may consider incorporating more explicit instruction on sensory-responsive practice within psychotherapy settings. Third, participants' distinction between therapists who identify as neurodiversity-affirming and those who demonstrate applied competence highlights the

importance of substantive literacy, as well as clearer definitions on neurodiversity-affirming practice. Clinician education may benefit from moving beyond awareness-based frameworks toward deeper engagement with lived neurodivergent experiences, including understanding masking, identity formation, and the relational impact of repeated invalidation. Transparency regarding training and ongoing professional development may also help support client trust. Clearer definitions on neurodiversity-affirming practice may also help support more consistent implementation across clinical settings. Sources of resilience identified in this study suggest that a more nuanced understanding of both autistic and ADHD traits may support strengths-informed therapeutic work with adults who have co-occurring presentations. Finally, this study underscores the importance of centering lived experience within psychotherapy research. By grounding the voices of adults with dual diagnoses, the findings contribute to a more nuanced understanding of what accessible and meaningful therapy may look like in practice. Continued qualitative and mixed-method research is warranted to further explore therapeutic processes and adaptations within this population.

Limitations

Several limitations should be considered when interpreting the findings of this study. First, the small sample size, while appropriate for in-depth qualitative analysis, limits the extent to which findings can be generalized beyond the participants that were interviewed, as their unique experiences with therapy were captured. The aim of this study was to explore lived experience rather than produce broadly generalizable conclusions. The experiences of adults with co-occurring ASD and ADHD may vary across contexts and identities not represented in this sample. Second, the demographic composition of the sample may limit the transferability of findings. All participants identified as Caucasian/White and four of the five participants, and most participants were also educated and employed. As such, the findings may not fully capture the experiences of individuals from racially, culturally,

socioeconomically, or geographically diverse backgrounds. Future research would benefit from including participants with greater diversity in race, ethnicity, sex, gender identity, education, income, and geographic location to better understand how intersecting identities shape therapeutic experiences.

Additionally, participants reflected on psychotherapy experiences across different time periods and therapeutic contexts. Given the already small sample size, the study did not restrict experiences to a specific therapeutic modality, timeframe, or stage of treatment. As a result, findings reflect a broad range of therapy encounters rather than a narrowly defined treatment experience. Future research may benefit from examining more clearly defined therapeutic contexts or timelines to explore how specific modalities or stages of therapy influence experience. Finally, some positive and negative factors identified in the findings appeared to interact with one another. For example, relational safety and accommodation were often described as intertwined, as were invalidation and pressure to change. While themes were presented separately for analytic clarity, participants' experiences were often complex and overlapping. This thematic separation may simplify the lived interconnections between relational, structural, and contextual factors within therapy.

Conclusions

In conclusion, the contributions of this research therefore include broadening current understandings of effective psychotherapeutic practice, promoting further empirical inquiry into mental health treatments for co-occurring ASD and ADHD, and providing clinicians with practical guidance for better understanding the therapy needs of this unique population. For therapeutic practice with adult clients who have both ASD and ADHD, the findings highlight the importance of a strong rapport and alliance to foster relational safety, focusing on the lived experiences of clients and the helpful role of tools, resources, and psychoeducation, as well as supporting clients' own self-understanding. Concurrently, they

also underscore the potential harms of invalidation, limited accommodations of sensory and communication needs, and pressures to conform within therapy. Together, these findings offer clinical guidance for practitioners working with members of this population.

Beyond individual clinical encounters, participants' reflections point to the need for enhanced therapist training grounded in collaboration, direct inquiry into individual preferences and support needs, meaningful neurodiversity literacy and affirming practices demonstrated in the therapeutic space rather than with terminology alone. Attention to sensory and environmental accessibility within therapy settings was also emphasized. As such, therapist competence when working with this population may be integral to ensuring that affirming principles are consistently enacted in practice. At a broader level, participants called for increased public understanding of neurodiversity that moves beyond stereotypes and one-size-fits-all assumptions, highlighting the need for more accessible mental health services and practical supports.

Ultimately, this study aimed to strengthen the understanding of therapeutic experiences of adults with both ASD and ADHD, striving for more accessible, responsive, and informed therapeutic care, while contributing to the breadth of neurodiversity research. Through capturing first-hand perspectives, this research contributes to a deeper understanding of what meaningful and effective psychotherapy may look like for members of this population. In particular, this study highlights the factors that facilitate engagement, the barriers that impede progress, the conditions under which therapy is experienced as supportive or meaningful, as well as taps into the self-perceptions of strength and resilience within this underrepresented population in research.

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