

4-5-2023

## The Social Support Experiences of Attention-Deficit/Hyperactivity Disorder (ADHD) Adults

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# **SOCIAL SUPPORT EXPERIENCES OF ATTENTION- DEFICIT/HYPERACTIVITY DISORDER (ADHD) ADULTS**

A Thesis

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
in partial fulfillment of the  
requirements for the degree of  
Master of Philosophy  
in

The Department of Communication Studies

by  
Lindsay A. Duede  
B.A., Drury University, 2020  
May 2023

## Acknowledgements

Before getting into the content of this paper, there are several people that I must offer thanks to for their support along the way. I truly have loved my time in this program and find myself feeling grateful for my time in Baton Rouge every single day.

I would first and foremost like to thank Dr. Colter Ray. I truly cannot imagine what my time at LSU would have been like without his guidance. As an advisor and as a committee chair, Dr. Ray has gone above and beyond to help me be successful and feel grounded. I am also grateful that he has given me a space to work in which my brain has challenged *and* supported. I am a far more competent scholar because of my time working with him.

I would also like to thank Dr. Kellie Brisini for her guidance, her kindness, and her time. Even before Dr. Brisini was on my committee she extended great kindness and support. Getting to share this project with her brought a wave of new life as she presented questions that challenged and pushed me to think deeper about elements I may have overlooked.

Next, I am thankful for Dr. Mary Lou Kelley for the time and wisdom she contributed to this project. As I continue to learn about ADHD and neurodiversity at large, it is necessary to explore psychological and neurological research. I greatly appreciate the perspective that she was able to share.

Of course, I owe the largest gratitude to my father, who has supported me through every wild change my life has already experienced. From Missouri to D.C. to Baton Rouge, my pops has been along for the ride fiercely at my side. From him I have learned what compassion, courage, and determination look like.

Finally, I would like to thank the family and the doctor that finally listened to *and* understood me. Often ADHD does not get recognized in young women; instead, we are told that

we have anxiety, depression, and a list of other mental health disorders. I have spent most of my life believing that I was a *problem* for the ways that I am different. On my worst day, I had a conversation with my cousin Megan that changed everything. As we sat on the phone, and I described my emotional state, she *saw* me in a way that my neurotypical peers simply could not. This was the day that I learned about emotional dysregulation and began my investigation into ADHD. The questions that I had been asking about myself throughout my life now seemed to click into place. I did not know that I was neurodivergent until a semester into my Master's program. As I have learned more about my brain, I have become a profoundly healthier and happier human being. I am so immensely thankful for the community of neurodivergent people I have surrounding me. This research, and all the work I hope to do, is for *us*.

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## **Abstract:**

Social support researchers commonly recognize that support is most useful when it matches the needs and desires of those receiving it. Yet, the majority of research regarding attention-deficit/hyperactivity disorder (ADHD) and social support frames questions of communication competence by placing neurodiverse communities at odds with neurotypical ones. This practice reinforces a hierarchy in which neurotypical individuals are viewed as correct and deviations from that norm as failures. Individuals with ADHD experience emotions differently than those without it; thus, it stands to reason that people with ADHD could have different needs and desires for support. Therefore, this study has two key goals: to explore the unique social support desires and preferences of ADHD adults and to explore the support gaps that might be experienced by ADHD adults. This is achieved through two studies. During the first study, ( $N = 20$ ) ADHD adults (18 years and older) participated in semi-structured interviews regarding their goals and preferences for social support and the obstacles they face in receiving it. Notably, all participants discussed the importance of procedural rules such as message timing as a key feature of their supportive experience. During the second study, a survey was distributed to ( $N = 286$ ) adults with ADHD to identify and analyze various support gaps. This study found a significant relationship between emotional dysregulation and the perception of emotional, esteem, and tangible support gaps.

## **Chapter One. Background and Rationale.**

Whether facing momentary conflicts or long-term complications, dealing with stressors is an inevitable part of the human experience (Burleson, 2003). Each stressor brings unique challenges that can, at least in part, be mitigated by receiving social support from the people in their lives. Supportive communication, as defined by Burleson and MacGeorge (2002, pp. 73) is the “verbal and nonverbal behavior produced with the intention of providing assistance to others perceived as needing that aid.” A well-established body of research supports the notion that receiving social support during or after a stressor can provide numerous benefits to the support recipient (Bodie, 2011; Burleson & MacGeorge, 2002; Cutrona & Russell, 1990; Holmstrom, 2012; Priem & Solomon, 2015). These benefits are explicitly discussed later in this paper; but it is foundationally important to note that the precise benefits are dependent on the greater context. Supportive communication is not one-size-fits-all. Although researchers have explored what makes some support more or less effective (High & Dillard, 2012). The desires, goals, and obstacles related to social support can vary considerably from person to person. Understanding how to effectively communicate social support to others is an important interpersonal skill that can help maintain and strengthen relationships (Afifi et al., 2016).

The relationship between maintaining social relationships and positive health outcomes has been well established (Holt-Lunstad & Smith, 2012; Wang et al., 2018). Notably, attention-deficit hyperactivity disorder (ADHD) adults and children consistently report higher levels of loneliness and social isolation than their neurotypical peers (Laslo-Roth et al., 2022; Stickley et al., 2017). This same population has also been found to experience elevated levels of depression, anxiety, trouble with self-image, among other mental health struggles (Björk et al., 2020; Daviss, 2010). This context creates an elevated importance for ADHD adults to receive effective social

support from the people in their lives. A plethora of research exists that asks neurotypical people to evaluate the ability of ADHD adults to provide them with social support. However, limited research exists that discusses the social support experience when the recipient is neurodiverse. It is for this reason that this paper explores the social support experiences of ADHD adults.

## **ADHD and Stigma**

Attention-deficit hyperactivity disorder (ADHD) is considered one of several neurodevelopmental disorders (NDDs) that occur in approximately 17.8% of the general population in the United States (Bolte et al., 2021). ADHD is reported as being experienced by approximately 5% of adults in the United States (Dakwar et al., 2012; Simon et al., 2009). Although still a minority population, with one-in-twenty people experiencing this condition it is not abnormal to know and interact with several ADHD people in both personal and professional contexts. Despite this, few research studies explore the distinct communication strategies of ADHD individuals and most research frames the dialogue around neurodiversity in terms of competence (Mastoras et al., 2015; Stenning & Rosqvist, 2021). A notable body of research refers to ADHD adults as an antisocial population with several communication deficits (Mastoras et al., 2015; Wymbs et al., 2015). This conclusion is often reached by utilizing a framework that evaluates communication competency through the lens of a neurotypical standard (Stenning & Rosqvist, 2021). This means that neurodiverse individuals, such as ADHD adults, have their competence evaluated by their ability to perform the same communicative strategies preferred by neurotypical masses. Even with the best intention in mind, this framework can have problematic consequences. This practice enforces a hierarchy in which neurotypical individuals are viewed as correct and deviations from that norm as failures (Stenning & Rosqvist, 2021).



Additional research has explored the negative effects of this stigma and otherization on the mental health of neurodiverse individuals (Björk & Rönngren, 2020; dosReis et al., 2010; Lebowitz, 2013). For example, children with ADHD are frequently labeled as having bad character, poor discipline, and other shortcomings. This research highlights that parents of ADHD children consistently report that stigma has greatly influenced their child's self-confidence and perception of ADHD. Lebowitz (2013) conducted a study in which one in five adults reported a desire for social distance between themselves and a fictitious ADHD child next door, with the desire for distance increasing as the child ages. This same research showed that many parents (23.5%) went as far as hoping their child does not befriend a young person with ADHD or even have them in the same classroom (19.3%). Furthermore, 77% of parents with ADHD children report also feeling isolated as a result of stigma surrounding their child. ADHD adults have an 85% comorbidity rate with other conditions such as anxiety, depression, bipolar disorder or autism spectrum disorder (Björk et al., 2020). Despite this overlap research has found that perceived ADHD can lead to more stigmatization than these other conditions (Lebowitz, 2013). This same research has cited common misunderstandings of the condition as a primary contributing factor. This stigma often leads to ADHD adults not receiving the support they need despite experiencing symptoms (e.g. anxiety, depression) that would otherwise be viewed as requiring social support.

### **Framing Dis-ability**

Stenning and Rosqvist (2021) establish a paradigm for discussing neurodiversity that guides important elements of this project's positioning. They begin by exploring the term neurodiversity and its relationship with the term biodiversity. Commonly, biodiversity is not only thought of as the differing kinds of living species but also in relation to the power structure in

which they exist. Similarly, ‘neurodiversity’ is used not only to describe various ‘kinds’ of brains but also establishes a sense of hierarchy. Neurodiversity commonly gets reduced to describing individuals who exist outside of what is considered cognitively ‘normal’ (Stenning & Rosqvist, 2021). Individuals who do not meet this normative standard are marked as impaired. Yet, in terms of neurodiversity, competence is generally regarded by the ability of a neurodiverse brain to perform the same operations as a neurotypical brain. Whereas biodiversity is regarded as necessary for an ecosystem to thrive, neurodiversity is often thought of as a problem that needs to be solved (Stenning & Rosqvist, 2021).

To date, the majority of research on neurodiverse brains uses a framework known as the ‘medical model’ (Dwyer, 2022). This views disability as pathological in nature; medical disorders that require some form of ‘curing’ of the disabled body. The medical model assumes that normalization of disabled bodies ought to be the goal of work conducted. For example, Sinclair (2012) discusses the importance of viewing neurodiversity as a way of *being* rather than as an appendage or ailment. Communication between individuals with varying neurotypes is complicated by the assumption of a shared communication system (Sinclair, 2012). Neurodiverse individuals are often taught to ‘mask’ or cover up their differences to camouflage into neurotypical communities (Dwyer, 2022).

This is the same communication strategy often referred to as *code-switching*, or altering speech style between various social codes to alter audience perceptions of the speaker (Bourhis et al., 2009; Giles et al., 1991). Communication accommodation theory (CAT) as discussed by Giles et al. (1987) discusses code-switching as making communication adjustments. Although adapting elements of your speech to an audience can have benefits, CAT also recognizes that there are social and psychological consequences for the individuals participating in this

phenomenon. Generally, it is speakers from less dominant social groups that are praised for their ability to mask their differences and appear *normal* (Giles et al., 1991). To avoid getting labeled as incompetent communicators by the general public, neurodiverse individuals often shift to utilizing neurotypical communication strategies. As a result, neurodiverse individuals have continuously reported anxiety, burnout, exhaustion, stress, and more as consequences of masking (Dwyer, 2022). Additionally, there is no locatable research done in which neurotypical individuals were asked to communicate using neurodiverse strategies. Meaning, neurodiverse individuals are evaluated on their ability to accommodate their speech to match neurotypical audiences while the inverse is simply not expected. This expectation stems from the medical model of disability describing disability as something to be corrected or overcome by the disabled individual.

To disrupt the narrative of the medical model, disability researchers discuss the value of using the ‘social model’ (Olkin, 2002; Stenning & Roqvist, 2021;). Here, ‘disabled’ moves from an adjective to a verb. This means that disability exists when an individual is dis-abled by factors in a particular environment. For example, an ADHD graphic designer may create creative, clear, and appealing designs but becomes dis-abled when the environment shifts to require extreme attention to detail. The social view respects dignity and recognizes the subjective and evolving nature of ability. This understanding allows for discussion of various neurodiverse experiences as they are opposed to seeking solvency for their way of being. This model also allows for an open discussion of the ways in which social conditions influence the presentation of ability.

Further, neurodiversity is just that: diverse. Whereas many neurodiverse individuals may have similar cognitive experiences, there is a wide spectrum in terms of how that manifests as behaviors. Reducing ADHD, autism, and other neurodiversities to fit one cognitive profile is

counterproductive and limits true understanding of these experiences (Stenning & Rosqvist, 2022). Therefore, it is important to highlight that although this paper is an exploration of common experiences among ADHD adults, it does not seek to assume any particular narrative for these individuals. This paper is committed to understanding neurodiverse people as they are rather than attempting to evaluate how we compare to any set expectation. Additionally, to avoid any further generalization of neurodiverse experiences this paper specifically engages with ADHD individuals while recognizing the need for more comprehensive engagement with other neurodiverse communities. This paper also recognizes the importance of framing competency in a way that does not extend ableist norms.

### **What is Competent Communication?**

Research commonly discusses the “incompetency” of ADHD adults’ supportive communication skills (Mastoras et al., 2015; Wymbs et al., 2015). Although this paper does not seek to evaluate the communication competency of these adults, it is important to unpack the framework in which this judgment has been made. Spitzberg and Cupach (1984) provided several definitions central to this conversation. First, is the important distinction between *skill* and *competence*. Here, skills are defined as “intentionally repeatable, goal-oriented behaviors.” Competence is explained as an “evaluative judgment of the quality of a skill.” For example, providing *an appropriate amount of* eye contact could be considered an important communication skill in interpersonal interactions. Here, an individual’s competence would be derived from others’ evaluations of how well the communicator performed that skill. It becomes necessary, then, to establish a rubric by which quality of ability can be measured. The behavioral assessment grid (BAG) was designed to help classify the various measures of skill assessment techniques (Cone, 1978; Spitzberg & Cupach, 1984). This model helps organize various methods

of assessing communication skills in terms of behavioral directness, content domain, and universes of generalization. There are hundreds of methods that attempt to evaluate the skill of a particular group of individuals, each setting up a slightly different rubric for evaluation.

Researchers Spitzberg and Cupach (1984) argue that the commonly used dual-criteria of effectiveness (*did I get what I want?*) and appropriateness (*do others find it acceptable and legitimate?*) provides the most useful gauge for measuring competence. This framework has been widely accepted and is often used in the evaluation of ADHD communication competency. It is crucial to note that appropriateness is inherently a subjective measure. Evaluation is based on an audience's understanding for and justification of *why* a person behaved or communicated in a particular fashion. Researchers recognize that the idea of what makes a good communicator can vary across age, class, cognitive framework, gender, religion, and a multitude of other qualities (Marin et al., 2019; Spitzberg & Cupach, 1984). By allowing evaluation to even partially rest on outside observers this conceptual framework perpetuates the evaluation of competence in terms of normative favorability. That is, if dominant social or cultural groups deem a behavior as normative, then those displaying different behaviors will be marked as non-normative, inappropriate, or illegitimate.

Communication, especially in the context of social support, is largely influenced by the experiences of the communicator. Despite this, neurodiverse individuals are rarely evaluated in terms of utilizing their skills in a goal-oriented fashion (Mastoras et al., 2015). Even less frequently do they get the opportunity to discuss what those goals are or their own perceptions of what counts as appropriate or legitimate behaviors. For example, an individual coping with the loss of a loved one is *allowed* to cry or ask for support without violating commonly understood rules of appropriateness. However, an individual displaying similar behaviors while coping with

the loss of a ballpoint pen might be marked as overreacting or *inappropriate*. The key difference between these situations is the audience's expectation for how an individual ought to respond. Losing a pen is not the same as losing a loved one. However, the signals of overwhelm, sadness, and grief still move through the same neurological channels. As discussed previously, neurodiverse individuals have brains that regulate these emotions differently than neurotypical peers. It is quite possible that the degree of hurt experienced in both circumstances could *feel* similar to a neurodiverse brain. Thus, responding in similar fashions may feel appropriate in context. Rather than starting with a preconceived idea of what qualifies as *normal* or *good* supportive communication, this paper explores the desires, preferences, and obstacles that ADHD adults perceive regarding social support.

### **What is Social Support?**

Generally, supportive communication refers to communicative efforts to help others in need (MacGeorge et al., 2011). A considerable body of research has shown the importance of receiving social support following a variety of stressors (Mastoras et al., 2015; Priem & Solomon, 2015; Thotis, 2011; Uchino, 2006). In addition to promoting feelings of inclusion, social support can have salutary effects on individuals' physical health such lowering blood pressure or deterring negative health behaviors such as smoking (Priem & Solomon, 2015; Thotis, 2011; Uchino, 2006). The precise benefits are dependent upon the context, including the specific support desires and preferences of the support recipient as well as the 'competency' of the provider to meet those needs (Cutrona & Russell, 1990).

Researchers Cutrona and Suhr (1992) have identified two main categories of social supportive communication: nurturant support and action facilitating support. Nurturant support includes three subcategories: emotional, esteem and network support. Each of these offer unique

messages that seek to comfort or console without directly addressing the stressor. Emotional support includes messages of caring, empathy and sympathy such as “I love you” or “you must have been really hurt.” Messages of esteem support focus on the competence and intrinsic value of the support recipient. This includes things such as “you are a great friend” or “you did good work on that project.” Lastly, network support focuses on messages of inclusion and belonging such as “you should join the team” or “you’re an important part of our friend group.”

Action-facilitating support includes both informational and tangible support. Both of these often seek to address the stressor through problem-solving (as opposed to the former sub-categories focus on emotion and appraisal). Informational support includes providing advice or relevant information. Tangible support involves providing material aid such as lending money or helping someone move.

Each of these distinct support types can play an important role in social support. However, the degree to which they are considered useful or effective may vary depending on several factors, including the situation, how well a supporter communicates support, and the support preferences of the receiver. McLaren and High (2015) elaborate on this with a discussion of *support gaps*. Support gaps are defined by the distance between the recipient’s desired support and the actual support they perceive. Receiving more support than desired results in an individual being *over*-benefited in that particular area. Receiving less support than desired results in being *under*-benefited. Generally, being over-benefited has been found to be more preferable than being under-benefited. However, depending on the context, both can have positive and negative impacts (High & Steuber, 2014; Holmstrom et al., 2021; McLaren & High, 2015).

**What is ADHD?**

ADHD is frequently reduced down to simply hyperactive and inattentive behavioral patterns. Common misunderstandings of ADHD have resulted in only 41.9% of adults being able to correctly identify ADHD based on descriptions (Lebowitz, 2013). Research explains that ADHD is not defined by behavioral onsets but can be better understood in terms of cognitive processing. Neuroscientists explain that, at its core, ADHD is about difficulty in regulation as controlled by the amygdala (Hulvershorn et al., 2014; Marsh & Blair, 2008). The amygdala is a region of the brain that controls various aspects of regulation and cognition (Marsh & Blair, 2008). Thus, ADHD individuals often face difficulty when it comes to stimuli regulation. This can manifest as hyperactivity or inactivity; emotional overwhelm or rapid processing; extreme focus or the inability to concentrate; and several other diametrically opposed experiences. ADHD challenges an individual's ability to *regulate* their responses to various stimuli and creates a unique lived experience for the individual.

The complex experience of ADHD includes several characteristics that are less known to the general population that are important to the scope of this project. These include emotional dysregulation (ED), executive dysfunction, difficulty with working memory, and impulsivity, among others (Bunford et al., 2014; Shaw et al., 2014; Shushakova et al., 2018). Each of these characteristics offer insight for the different ways in which these individuals might experience their emotions. Thus, before this project can progress it is essential to have an understanding of each of these concepts and how they may affect the social support experience.

Emotional dysregulation has been identified in approximately 70% of ADHD adults (Shaw et al., 2014). Despite the need for further exploration of this condition, researchers do consider ED to be a core experience of adulthood ADHD (Retz et al., 2014). ED can be identified by markers such as difficulty with emotional inflexibility, pressing anger, extreme



sensitivity to criticism, issues with self-conceptualization, lack of behavioral control, and sudden mood changes (Bunford et al., 2014; Hirsch, 2018; Shaw et al., 2014). Emotional dysregulation refers to trouble with *regulation*; not with the chemical balance itself. Much of the research conducted on ADHD in adolescents and adults alike classifies behavioral consequences of ED as “inappropriate outbursts” (Hulvershorn et al., 2014; Wehmeier et al., 2010). Notably, this body of research makes an underwhelming attempt at accounting for the experience leading up to this behavioral display. Neurological research, however, explains that the sudden onset of intense emotions exists as a procedural overwhelm in the amygdala (Bedrossian, 2021; Herrmann et al., 2010; Hulvershorn et al., 2014;), which is the area of the brain responsible for emotional regulation. This exasperates difficulties with other processes such as motivation, impulsivity, or cognitive processing that also occur in the same area of the brain. While experiencing ED, individuals are essentially processing a stressor while locked into fight-or-flight mode.

Amygdala overwhelm can cause difficulty with executive function. Although this struggle does occur during moments of ED, executive dysfunction can occur even in moments of low emotional stakes. Executive dysfunction can manifest as difficulty with working memory, delay aversion, and response inhibition (Karalunas & Huang-Pollock, 2011). Trouble with working memory can make it particularly difficult for individuals facing a stressor to hold the full context in their minds well enough to process it.

Delay-aversion is fairly straightforward as it refers to a motivational style that is averse to delays. ADHD individuals may not struggle to do a task that is deemed “urgent” because the consequences are immediate. Meanwhile, an important task might take longer to complete simply because the effect of not completing this task is delayed. When it comes to processing stressors, ADHD individuals may be more likely to choose short-term strategies as they will see

the outcomes quickly. Further, response inhibition is commonly explained as the ability to stop an ongoing response (Barkley, 1997). Once an ADHD individual is on a particular emotional path, disrupting that neurological process is difficult. Trouble with executive function has been shown in around half of all ADHD individuals (Karalunas & Huang-Pollock, 2011).

These experiences make it particularly important, and difficult, for individuals with ADHD to positively reappraise a stressor (Cauwenberge, 2017). After conducting a meta-analysis on positive reappraisal, Nowlan et al. (2013) defined this as “a meaning-based cognitive emotion regulation strategy that... involves finding personally relevant positive meaning from an experience in the face of its negative reality.” Simply put, positive reappraisal is the process of reframing a stressor in a more positive light (Lazarus & Folkman, 1984). ADHD adults find this especially difficult given that it relies on internalized regulation mechanisms. However, research by Young (2005) has identified a unique positive relationship between impulsivity and an ADHD adult’s ability to ‘bounce back’ from emotional stressors. This has been partially attributed to the impulsive nature of ADHD leading an individual to focus more on short term coping than long term strategies (Shushakova et al., 2018; Young, 2005). As discussed, emotional dysregulation heightens the emotional experience and can make it extremely difficult for an individual to see the full picture enough to employ long-term coping strategies. ADHD individuals have been shown to increase success with long-term coping strategies when guided or supported in the process (Hagstrøm et al., 2020; Newark, 2010). In a study regarding the benefits of intervention on the well-being of adults with ADHD, researchers found that offering information and resources increased feelings of safety (Sehlin et al., 2018). Other studies recognize that providing ADHD individuals with information regarding their cognitive profile

and providing language for their experiences can also benefit their mental states and coping processes (Bramham et al., 2009).

However, ADHD individuals are significantly less likely than the neurotypical population to ask for the support that they need. Often, the decision to not seek support is preceded by struggling to identify a robust social network or support system (Mastoras et al., 2015). This means that although various forms of support *may* be helpful, seeking that support has proven difficult for these individuals. This paper's first study uses qualitative methods—more specifically, semi-structured interviews and thematic analysis—to explore the supportive communication processes as experienced by ADHD individuals. These interviews seek to understand the goals, preferences, and struggles of the social support process for ADHD adults and are detailed in greater depth in the following chapter.

## Chapter Two: Study One

### Study One Rationale

#### Support Goals

In this paper, I use the word *goals* to discuss coping preferences of the individual experiencing the stressor; or essentially, what they hope to take away from a social support encounter. There are many possible goals for dealing with a stressor including processing, reappraisal, emotional cushioning, and changing the environment (Burleson & Mortenson, 2003). Research has shown that individuals typically find that certain types of support are more helpful when it is aligned with their goals in a given context (Burleson & Mortenson, 2003; High & Solomon, 2014; MacGeorge, 2010). For example, someone who is seeking support with the goal of eliminating a stressor would not necessarily be satisfied by support that only seeks to curb their negative affect towards it, although emotional support is typically viewed positively across stressful situations that vary in controllability (Cutrona & Suhr, 1992). Often, research references reappraisal as a highly desirable goal for individuals (Burleson, 2009; High & Solomon, 2014; Lazarus & Folkman, 1984). This claim is based on the long-term benefits that have been identified when an individual does the cognitive labor that reappraisal demands (Burleson, 2009). Comparatively, avoidant behaviors are often classified as less likely to promote long-term coping and seen as less favorable (Burleson, 2009).

Some studies suggest that ADHD adults are able to use avoidant coping strategies to aid in their process of reappraisal (Bodalski et al., 2018; Young, 2005). That is, following a stressor, ADHD individuals seek to diffuse the amount of attention directed at the problem, and can achieve this through avoidant tactics that weaponize their impulsivity and ability to bounce back quickly. From the outside, this process has been referred to as being “overly optimistic”

(Bodalski et al., 2018; Knouse & Mitchell, 2015). Notably, this judgment has been made largely by neurotypical populations who generally do not experience the immediate psychological consequences of emotional dysregulation. ADHD individuals engaging in avoidant coping strategies are perhaps attempting to diffuse the emotional overwhelm that they are experiencing related to the stressor. Scholars have developed a cognitive reappraisal strategy for ADHD adults called SPEAR: Stop, Pullback, Evaluate, Act, and Revaluate (Newark & Stieglitz, 2010). This process emphasizes the utility in distancing oneself with a stressor before attempting to evaluate it. The cognitive impulsivity ADHD adults naturally possess can work for or against them. If an ADHD adult is asked to process a stressor as it is occurring then they are likely to hyperfocus on the negative qualities. By using their impulsivity to avoid and strategically distance themselves from a stressor they are able re-evaluate and act in a way that can better serve their long-term goals. This process allows them to weaponize their impulsivity in a way that helps them quickly reappraise the situation and bounce back (Bodalski et al., 2018; Knouse & Mitchell, 2015). This paper explores the rationale for choosing various coping strategies by asking participants to identify their goals for coping during and following a stressor.

### **Support Preferences**

This study discusses preferences in terms of the qualities of and the type of the social support that individuals desire. Qualities can include particular aspects of what people prefer such as message content, message timing, provider relationships, delivery style, and more. Types of social support have been delineated into two main categories: action-facilitating (informational and tangible) support and nurturant (emotional, esteem, and network) support. Researchers have shown that on average many people prefer support that seeks to comfort their affect towards a given stressor (Cutrona & Suhr, 1992). This indicates simply that people want

the support of others to *try to make them feel better*. This does not, however, imply that any particular type of support universally seems helpful in that endeavor.

Preferences for support can be influenced by a variety of factors. First, this may be impacted by the degree to which a stressor is seen as controllable by the support recipient or provider (Cutrona & Russell, 1990). When the *recipient* does not perceive having control over the stressor, they tend to report preference for emotional or esteem support (Cutrona & Suhr, 1992; Eichorn, 2008). Additionally, these individuals in this context commonly report low satisfaction for action-facilitating support (Cutrona & Suhr, 1992). When the recipient perceives a stressor as controllable by either themselves or the support provider they are more likely to report satisfaction when met with action-facilitating support types (Gray, 2014). Notably, emotional support was met with high recipient satisfaction regardless of the stressors' perceived degree of controllability by either party (Cutrona & Suhr, 1992).

Preferences can also be influenced by the content of a message being communicated. Scholars have discussed this in part by looking at the degree of person-centeredness that a message contains (Bodie et al., 2012; Burleson, 2003; High & Solomon, 2014). A highly person-centered (HPC) message seeks to directly acknowledge and affirm an individual's emotions and are often shown to improve recipient affect. Comparatively, low person-centered (LPC) messages deny or condemn the individual's feelings and often challenge their legitimacy. Although hurtful messages *can* be effective in specific contexts, researchers have highlighted the general problematic and unhelpful nature of LPC messages (Burleson, 2003; Zhang & Stafford, 2008). In moments of support, research has shown the importance of validating an emotional response or behavior; even if the support provider may not fully understand the response. This is particularly important to consider when the recipient is an ADHD adult.

Additionally, an individual's preferences may also shift along with the relationship with the support provider. For example, an individual may prefer highly person-centered messages of emotional support when coming from a loved one; but feel uncomfortable when that same support is provided by a professional colleague. One contributing factor to this shift may be the recipient's relationship and trust with the support provider (Burleson, 2003; Ommen et al., 2008).

It is also important to note the impact various demographic factors such as age, cultural background, education, gender, may have on supportive interactions. Education, for example, has been identified as having a negative relationship with levels of anxiety and maladaptive coping (Drageset & Lindstrøm, 2005). Some studies also suggest that the gender of both the recipient and provider may have an impact on the support preferred. For example, women tend to desire *and* provide more support overall than their male counterparts (Xu & Burleson, 2001). This is especially true in the context of emotional or esteem support. There are a plethora of other demographic and cultural factors that may impact an individuals' preferences for support. This paper hopes to expand that understanding by inquiring about the preferences uniquely established by ADHD adults.

## **Obstacles**

The social supportive process is further complicated by various obstacles that may appear. These obstacles could be external factors that block an individual's ability to access support or internal factors such as difficulty communicating needs. Researchers have also identified a phenomenon known as *nonsupport* in which an individual chooses not to provide support to someone perceived as in-need (Ray & Veluscek, 2018). There are many reasons that a potential provider may choose to not offer social support (Ray et al., 2019). For example, individuals may feel that they are not the best actor to provide support and choose instead to

distance themselves from the individual. Additionally, a potential provider may not feel comfortable with their ability to provide accurate and helpful support and decide to not communicate support. Even when support is offered, an individual must perceive it in order to absorb the benefits (Chu et al., 2010; Haber et al., 2007; Priem & Solomon, 2015). Other scholarship argues that because visible support risks consequences from *getting it wrong*, invisible support may be able to provide benefits to the recipient without accruing this risk (Bolger et al., 2000; Zee & Bolger, 2019). Invisible support gives support providers the opportunity to act without immediate observation and scrutiny of their actions. It is less likely that these individuals will be able to critique the support directly if it is occurring in the background. While in this circumstance the recipients may not be able to cognitively attribute benefits to the support provided, individuals often report more positive appraisals of stressors following this type of support (Bolger & Amarel, 2007).

ADHD adults have several of these obstacles exacerbated by inherent elements of their neurotype. The combination of inattentive and impulsive behaviors make the process of conceptualizing the breadth of a stressor difficult for ADHD adults (Mastoras et al., 2015). Meaning, the first obstacle that an ADHD adult is likely to encounter involves their internal conceptualization of the stressor. The experience of emotional dysregulation further complicates this by causing procedural overwhelm in the amygdala. This experience can increase the prevalence of executive dysfunction, or the individual's ability to execute a task such as requesting support (Karalunas & Huang-Pollock, 2011). This paper seeks to give voice to ADHD adults to elaborate on the obstacles they face with receiving and perceiving social support.

To summarize, a plethora of research exists examining how neurodiverse individuals, including those experiencing ADHD, fail to communicate and meet the supportive desires of



others (Mastoras et al., 2015). Yet, minimal research exists that seeks to understand *why* this is the case. Individuals with ADHD experience emotions differently than those without it, thus; it stands to reason that people with ADHD could have different needs and desires for support. Rather than accepting a monolithic view of social support competency, this study focuses on the experiences of these ADHD adults as they are. To accomplish this goal, three research questions are posed:

*RQ1. What goals do ADHD adults have for receiving social support?*

*RQ2. What are the preferences of ADHD adults when receiving social support?*

*RQ3. What are the common obstacles to receiving support experienced by ADHD adults?*

## **Study One Methodology**

### **Participants**

Participants ( $N = 20$ ) were recruited for semi-structured interviews conducted and audio recorded on Zoom. Recruitment occurred through announcements on social media platforms including Facebook, Twitter, and TikTok. All participants were adults (18 years of age or older at the time of participating) that self-identify as experiencing ADHD. To limit barriers to participating, adults participating in this study were not required to have a medical ADHD diagnosis. Instead, interviews were prefaced with a brief screening questionnaire to evaluate the prevalence of symptomatic ADHD. Demographic information for this sample appear as Table 1.

***Determining Participant Eligibility*** The Adult ADHD Self-Report Scale (ASRS v.1.1) was used to screen for adulthood ADHD. This is a validated 18-item measure that includes two parts (Kessler et al., 2005). Part A was used as an ADHD screening mechanism and contains six items that get scored based on severity of each symptom. Individuals with a score of four or more were chosen to participate in the study. Part B contains 12 items that operate as a subscale

using DSM criteria to probe further into patients' symptoms. For each item, respondents indicated the frequency each item is experienced. Prior research has supported this scale as an effective and reliable measure of adulthood ADHD (Adler et al., 2006; Adler et al., 2018; Hines et al., 2012; Stanton et al., 2018).

## **Procedures**

Approval for this project was obtained from the researcher's university's institutional review board. Eligible participants were contacted to schedule a semi-structured interview over Zoom. Interviews lasted between 21 and 61 minutes, with an average length of 39 minutes and 28 seconds.

The script used for interviews appears as Appendix 1 of this paper. The first half of the interviews asked open-ended questions that allowed participants to express their perceptions of various factors of social supportive communication. Questions in this section explored both RQ1 (goals for social support) and RQ2 (support preferences). This was done by asking the participants to contextualize our discussion by elaborating on a recently experienced stressor. Participants were then asked to reflect on what they wanted out of the interaction as well as what makes support *work* for them. The second half of the interview asked participants to reflect on the way social support has generally been provided and/or obstructed for them. Here, they were asked to elaborate on *why* certain types of support felt more or less useful. Examples of these questions can be identified in Table 2.

## **Data Analysis and Data Verification**

Following the interview process, abductive thematic analysis was conducted on the collected data. Abductive thematic analysis acts as a middle ground between deductive and inductive methodology (Coffey & Atkinson, 1996; Thompson, 2022). Abductive reasoning

occurs when an individual makes observations and utilizes existing evidence and research to infer the best explanations. This method of analysis allows for the integration of framework from current literature with the exploration of novel ideas. As applied in this paper, current literature played a foundational role in the types of codes that the researchers began the process looking for. The nature of this method allowed researchers to remain flexible to interpret responses without forcing their answers into preconceived ideas. Abductive thematic analysis allows researchers the freedom to theorize explanations for relationships in the data set. This is another distinct advantage from other forms of thematic analysis. This allows researchers to use current literature as a guide rather than as a rubric to interpret their findings (for additional information on abductive thematic analysis, see Thompson, 2022).

To begin, interview recordings were transcribed by the lead researcher. Transcribing by hand was advantageous in that it helped the researcher naturally gain a sense of familiarity with interviews prior to re-reading them (Braun & Clarke, 2006). Once transcriptions were complete, the lead researcher and another member of the research team continued familiarizing themselves with the dataset by reading and rereading the interview transcripts. Next, these two researchers independently developed codes that connected specific raw data with their cognitive understanding of that message (Seidel & Kelle, 1995). Notably, abductive analysis views codes separately from themes in that codes are specific whereas themes can be relatively broad. (Thompson, 2022). These independent codes were brought together to develop a codebook. Next, researchers combined and moved codes to look for relationships between them. Researchers on this study developed and analyzed their codebook during two data meetings that occurred over Zoom.

In the first of these two data meetings, the researchers discussed the codes they independently noted after reading the first 12 interviews. Both researchers identified three similar themes for RQ1, which explores goals for social support. One researcher had identified a fourth theme throughout the research that the team agreed should be included in the final codebook. For RQ2, there were a total of seven themes identified between the researchers. The researchers were able to revisit their coding schematics and discuss the relationships they used to create themes. Together they were able to restructure these codes into three distinct themes that would allow for them to remain in conversation with current social supportive literature without limiting participant's responses. For RQ3, researchers identified a total of eight distinct potential themes and only one shared. Again, once researchers elaborated on their connections between codes they were able to find overlap and create a total of six themes for the research question.

After this initial meeting, researchers independently coded the final eight interviews to ensure that emerging themes were consistent with the codebook. A second data meeting was held after coding the remaining interviews and neither party expressed a need to modify the scope of the themes for RQ1 or RQ2. By successfully applying the themes derived from the first 12 interviews to the remaining eight interviews, referential adequacy was achieved. For RQ3, researchers agreed that the six themes could be condensed into only five while still maintaining integrity. The results and interpretation of these themes are outlined below. All quotes are attributed to pseudonyms chosen by the participant or assigned by the lead researcher.

### **Study One Findings**

#### **RQ1: What Goals for Receiving Social Support do ADHD Adults Have?**

The first research question explored what ADHD adults desire in terms of social support. Within the sample, four distinct themes emerged. The first two themes, validation and coping,

both focus on the individual's goals for their emotional state during the stressor. The second two themes, understanding and remedies, were related to the individual's goals for addressing the stressor itself. These themes are outlined below.

### ***Validation***

Participants wanted their support systems to validate their emotions *and* their processing of various stressors. Participants commonly reference heightened emotional states during stressors that can impact their behavioral decision making. These individuals explained that they want a support network that can accept those outbursts and help them feel validated and understood for their responses. Participants explained that, even if their emotional processing of a stressor was congruent to their support providers, it is important to them to not be reprimanded for how they have handled the situation. As Abby expressed, “Even if I upset them by my response that they don’t take that to heart”. These participants were aware that sometimes their processing could seem jarring to others and explained that support could be validating by simply being consistent. Elizabeth discusses this as:

“The people in my life understanding me in a way that they don't get upset or offended by sometimes my unstable emotional state. For example, I struggle with depression very often, but sometimes it is in those stages that are unbearable, I guess. And so to me, if someone that I love and someone that's in my support system can love me through those moments.”

### ***Coping***

In this theme, participants expressed that they want to use the supportive process to help them emotionally cope with a problem. Many participants acknowledged the way that emotional dysregulation can impact their own experience of a stressor. This elevates the importance of their desire for help grounding and *realizing* their emotions. When discussing addressing a stressor without this support, Alex said,

“I compartmentalize, I put that shit away. Stuff that bothers me, I put that shit away. It’s packaged and sealed, it’s done with. It takes a lot to draw it out of me. I feel like when I do have emotional bursts it... it comes out all at once. You can get anger, sadness, frustration, all at once.”

In various contexts, these participants explained how their development of these skills may have been shunted. On this, Annabelle said, “It kind of has a lot to do with my parents because they never really allowed us to express any kind of emotion. And when we did express emotion, it was met with anger and discomfort.” Notably, as participants discussed coping, they explained it as an important *short-term* strategy for getting through the bulk of the stressor. Cici added, “My initial goal is to just be able to cope with it because unfortunately the world doesn’t stop it for us.” These participants explain that their emotional states can sometimes interrupt their performance ability and thus have to address it first. Additionally, participants explained that this element of the process is particularly important for them as they practice identifying and communicating their own emotional states.

### ***Understanding***

Participants mentioned that when facing stressors they find themselves hyper-focused on specific negative aspects. As these participants work through stressors they want their supporters to help them better understand the stressor. Otto explained, “Good support would be being able to help me see the big picture. And it tends to be very hard for people to be able to understand my approach and be able to walk with me on my roundabout path to dealing with the stress.” Wanda added that this looks like “verbally, being very grounding in the sense of helping me kind of work through my emotions and steps from pinpointing the stressor to why I feel agitated or sad.” Participants explained that their desire for this type of support can be particularly traced back to elements of their ADHD. As Reed expressed:

“ADHD can be really hard. Like I said, a lot of the problem is even like conceptualizing the solution. With so much going on in your head, there's the problem itself and then how it intersects with all kinds of whatever personal history anxieties that aren't even adjacent to the problem. They somehow come in and muck things up. Even conceptualizing the solution, conceptualizing the problem. It's a lot. We do the best we can.”

Within the sample this desire for understanding manifested in two distinct fashions. First, some participants expressed a desire for their support systems to ground them in a context by explicitly reminding them of the full scope of the situation. For example, Wednesday, who identified a stressor caused by short-term thinking habits, said her support network would be most helpful if they helped her remember the long-term implications of her decisions. “Maybe if they were like... ‘Hey, you’re going to see Taylor Swift in April. You should probably save up money because you’re going to want to buy everything in the merch stand.’ I’d be like, ‘you’re right. I probably should work more.’” James elaborated that “It feels like what I want is very clear expectations.” These individuals want their support networks to help them remove gray area and define context.

Second, participants expressed a desire for understanding by asking their support network to help them work through the stressor by breaking it down and asking questions. This is distinct in that these participants are expressing desire for support that aids them in external processing measures without necessarily providing any type of information or feedback. Otto said, “If I just tell you about it, I’m, for one thing, I’m realigning my thoughts and I might think of something that I didn't realize just by externalizing it.” These participants want a support provider to help them *process* the stressor by working through it *together*. Cici elaborated on this process as:

“What I frequently do ask from my support system is that they sit down and help me either A) analyze the problem and my feelings in it and why I think I’m feeling those feelings. And come with hopefully some steps about what I can do to break down the problem and in a more concise way and in a more manageable start to resolve the issue. I have a lot of problems just looking at the big picture and it can be overwhelming to try to talk or something when it seems stupid to tack off. So to be able to make it down into

small manageable steps and be able to work through as a problem definitely helps me specifically.”

### ***Remedies***

The fourth dominant theme in this sample was that individuals wanted supporters to help them find and execute potential remedies for their stressor. Reed expressed that he was looking for “somebody who can listen and provide avenues for the remedy of the problem.” Interestingly, the actual execution of the solution was not as central in this conversation as simply identifying possible routes. Logan describes what he’s looking for by saying, “It’s going to be usually the ability to listen and help me create a plan of attack.” Participants valued supporters that can help them come up with possible solutions. Often, they explained that by identifying *possible* solutions they were able to feel some relief, even before the actual problem solving took place. Paige explained that:

“Once I find a solution for something I feel, like, almost immediately better. Even if, like, for this particular instance, it hadn’t actually been taken care of yet. But I knew what I was going to do. I immediately felt better. So I bounced back pretty fast once I did find the solution.”

### **RQ2: What Preferences for Receiving Social Support to ADHD Adults Have?**

In this research question, I explored ADHD adult’s preferences for social support in a few different paradigms. Within each paradigm distinct patterns emerged which are explained below. The first theme explores their preferences in relation to Cutrona and Suhr’s (1992) five types of support. The second theme explores preferences in terms of the coordination process. Finally, the third theme discusses their preferences in terms of facework.

### ***Typology of Support***

***Emotional Support.*** Emotional support was generally noted as being appreciated by the participants. These participants often explain emotion support as a baseline form of support that



they would consistently desire from their network. Jennifer said, “I like to just have somebody there to say that they care about me and they're there to be there for me, even if it's the simplest thing of just sitting next to me while I'm going through it.” In general, participants seemed ready to at least welcome this type of support if it was to be offered to them.

Participants extend this by explaining that emotional support may help buffer an emotional response, but that it does not frequently help the actual stressor in context. Leo added, “During stressors, I experience, like, physical response, like physical I don't know, like physiological responses, I guess. And so adding to that would not be helpful.”

Additionally, several participants, including Jimmy, expressed potential discomfort when receiving direct messages of emotional support. He said, “I get that a lot, but I don't really know how to respond to it. I'm not the most emotional person but... I try not to, like, deny? Or shut that out?.” Some participants, including Bernice, elaborated that this discomfort is from perceiving the support as disingenuous. She said:

“ I don't always take them as genuine because I feel like in some instances I've also offered platitudes to people and an attempt to make them feel better. I don't know how well that works for other people. I think for me it means a lot, especially if I'm not actively in a bad space. But when I'm actively in a bad space, I don't know if that's always the best answer.”

***Esteem Support.*** In general, responses to receiving esteem support were fairly critical. Winston summed up his response by saying, “I don't personally bite on those very hard.” Participants seemed to be thankful for the effort but very few seemed to find this support useful. CiCi explained, “As I have grown up, words of affirmation didn't make me feel any type of way because it's just like fodder. It just felt like someone was just saying it to say it.” Participants explained that esteem support works best for them when it is paired with something more tangible. Otto added, “So maybe I'm thinking, that's cool, but the reality is I really could use an

umbrella. It's a great sentiment. It is a great sentiment, but since I don't believe in myself, I really don't know what you smoke.”

**Network Support.** Out of the three types of nurturant support, network support seemed to be the most accepted. Participants generally viewed this support as useful and comforting.

Jennifer explained:

“That I do feel like is helpful because then it's people who are understanding of the situation. Because whenever you are in a situation like that and you have somebody who's trying to be supportive that doesn't understand what's going on, it can actually almost be more harmful for the situation.”

One explanation for this is that they may feel more understood by the new connection than they did by the original support provider. They also expressed appreciation for the awareness that it would take for a support provider to connect them with someone useful. Other participants, however, were skeptical that it would even be possible to connect them with someone with similar experiences or struggles. Alex explained, “I don’t like that idea. At all. I have always identified myself as being unique and individualistic.”

**Informational Support.** Participants understood informational support in two distinct ways: advice and information. The reactions that participants had to each version drastically differed. In general, participants appreciate hearing advice from loved ones, but made sure to say that they do not always find it useful. The biggest reason for this was that participants felt that the advice they are given does not resonate or exhibit true understanding of the situation. James said, “Mainly just because advice like this, unless it comes from someone very close to what’s going on, doesn’t seem to get at the actual problem.”.

Participants also explained that their resistance to advice is largely determined by their headspace when they are receiving it. These individuals commonly want their support network to

provide them with avenues for solvency, but only once they are ready to hear it. Bernice explained this process as:

“If I was going to someone, especially if I'm extremely upset or manic or something like that and I'm explaining to them what I'm needing to do in all this and they try to give me advice while I don't mean to, half the time I've already thought of what they've said and that makes me more upset. Is that the best response? No, it's not. But sometimes receiving that advice when I'm not in the right headspace makes it worse, like, do you think I haven't already thought of that? Or yeah, you might think that's the answer, but you don't realize X-Y-Z that makes your answer not actually solve anything.”

The second tangent of informational support is providing information and resources to the support recipient. Across the board participants indicated a high desire for this type of support. When experiencing a stressor, ADHD adults may struggle to fully digest the context or stay grounded. In these instances participants consistently expressed a sense of gratitude for support providers that use information to help pull them ‘back to earth.’ Wanda explained that she wants someone to help by:

“Kind of placing me back into the moment whenever I feel like I'm having some kind of disassociation state. And in that moment I feel like the world is spinning around me. So any kind of words that are just like, ‘hey Wanda, you're sitting in your house right now in your papa's on chair, there's cats rolling around you, there are two pairs of shoes on the ground and there's a pair of socks in a bag.’ Those kinds of things kind of put me back into reality where I don't feel so trapped.”

Participants also expressed how receiving information on their ADHD has been tremendously helpful for confronting stressors. Many of these individuals explained that simply receiving an ADHD diagnosis helped them put words to what they were experiencing and find new methods of handling stressors. James said, “Being able to label it burn-out and then being able to dovetail that into the ADHD stuff, naming the ADHD and getting directed therapy for that, that seems to be the thing that really helps me long term.”

***Tangible Support.*** In terms of tangible support participants were generally willing to accept the support, but were most appreciative when the support was directly related to solving

the stressor. Abby talks about receiving this support and said, “I guess it depends on if the gift was useful to the situation. If it’s not then it would be a nice thought, gesture, but if it wasn’t helpful... I don’t see the point in it.” Other participants discussed tangible support as a way to help distract from the stressor in ways that might be useful for their long-term processing goals. Vanessa said, “Offering me something to break the hyper focus is always going to be a good thing for me.” In general, despite asking for tangible solutions, participants struggled to see much use in the way their support networks commonly provide them with tangible support options.

### ***Facework***

Across the board participants expressed a strong desire to maintain a positive face. Scholarship has identified two primary types of positive face: fellowship face and competence face (Lim & Bowers, 1991; Ray & Veluscek, 2017). Fellowship face is tied to a sense of belonging or desire to be included. Participants expressed this as a desire to be thought of by the support providers without having to reach out for the support. When discussing good support, CiCi said: “They are around to support you and if they aren’t they make an effort to let you know that so they wish they could be more supportive but they are still thinking about you.”

The other type of positive face, competence face, focuses on respect for someone’s intelligence or ability. While many participants expressed a desire to have their fellowship face protected through affirmations, most participants expressed fear of damage to their competence face. In fact, several participants cited exactly this as the reason that they prevent themselves from asking for support even when they already know that they need it. Annabelle expressed that she wanted to protect her competence face by saying, “It would make me, honestly, at first feel a

little disappointed in myself... I am very hard on myself and so I don't like other people seeing me in situations where they're like, 'hey, I think you need help.'”

Participants explained that they appreciate support that does not take away their sense of independence or control over the situation. Many individuals explained that they can appear strong to others as a result of coping through previous stressors. Wanda explains the effect this perception of her face has had by saying:

“I don't want to be viewed as broken or damaged from anything that's happening in my life. I think that also stems from being told that I'm a strong, confident person my entire life. More of a reward for having a crappy life or childhood.”

### ***Procedural Rules***

Perhaps the most prevalent theme within this research question is that of procedural rules. This theme occurred when participants were particularly concerned about the process in which support gets offered to them. They discuss this on two fronts: in terms of coordination and attentiveness.

First, coordination refers to the transition to and timing of support as well as the ebb and flow of specific conversations (Spitzberg, 2013). In nearly every interview participants explained that in order to process a stressor they need a moment to pause and step out of the context. This can look like removing themselves physically from the environment or just being given a moment to pause before being asked to cope with or address a stressor. They explain that being allowed this moment of removal can help them gain control over their emotions during dysregulation and gain a better sense of awareness. Annabelle expressed this as:

“A big thing for me when I get really stressed out, really upset or feeling different, conflicting emotions. I know that a good thing for me is to kind of self isolate really quick, even if it's just for a few minutes, and kind of just cool back down and come back and really think about what just happened that upset me.”

Participants further explain that taking this moment away is more about *their* internal process demands than it is about the context of the support provider. These participants explained what it is like to experience emotional overwhelm. Jimmy explained how he handles the need to get away:

“I don’t smoke, but I take the smoke break because that’s the only way I can do it... If I’m dealing with a stressor that I can’t physically identify I tend to catastrophize. And by that I mean I will mentally envision the worst case scenario and then my brain will spend the rest of the next hour to try to convince myself that the worse case scenario is the status quo. That the big boogymen in my head is the thing. I don’t really have a resolution for that one. That’s one where I just have to take myself out of the situation and re-examine it in a new light.”

Other participants explain this momentary pause as essentially letting the wave pass without resisting. Here, procedural rules still govern their desires for support. Bernice explained the importance of timing to her as:

“More than often, it's just I need a meltdown, and I need to melt down and then calm down to express those emotions. And I think people need to understand, or I would like for them to understand that those meltdowns aren't bad. You don't need to make sure they stop as soon as possible. You don't need to try and force me out of that head space. It's usually better for me, and I just need to cry it out and go take a nap, and then I will be better.”

Second, attentiveness refers to the process of listening, providing empathy, and asking questions to the support recipient (Spitzberg, 2013). Participants wanted support providers that can help support their own process in searching for solvency by asking questions and letting them talk it through. Otto discusses his preferences as:

“It's not a matter of let me tell you how to take care of it. It's not a matter of let me do it for you. It's more like, so tell me what's going on, eliciting my own view of it and not interrupting too soon with a well, that's not that big a deal. Just let me talk through it.”  
Even participants that expressed a strong desire to have their support providers give them

direct solvency were particular about the way they want that solvency to be presented to them.

Winston explained how his network can best support him. Here he said:

“Probably like every other human being I would prefer to be led in a direction rather than be told what to do. I think that’s probably everybody. Someone says well you should do this and this... Instead I think a superior way to go about it would be hey okay so what are you going to do about this problem? Well what are you going to do about that problem? And then we can work through leading in a direction as opposed to giving directions. It will just tend to go down a lot easier.”

### **RQ3: What are the common obstacles to receiving social support for ADHD adults?**

With this third research question I wanted to understand what obstacles exist for ADHD adults in receiving support. Here, five key themes emerged. Four of these themes largely relate to reasons why the participants do not find themselves communicating to their support networks that they need support. The final theme consists of practical matters that may interrupt access to the supportive process.

#### ***I Am Misunderstood***

In this theme, participants explained that they often do not consider asking for support because they do not have faith that their support providers will provide them with their desired validation. Wanda explains why she feels this way as, “You’ve never been through it. You’re not going to understand what I’m going through... It has to be very specific people for me to be able to feel comfortable in asking or even mentioning it.” Additionally, participants remark on times in which they have reached out for support only to have that request belittled or themselves otherized. Bernice recounted one experience as:

“I’ve had a conversation with someone who I thought I could trust, and then I said something to them, and they responded, essentially being like, basically what I had said to them was something weird. ‘Do you get what I’m talking about, though? You know what I mean?’ And they’re like, ‘no, I never know what you mean. You say some of the weirdest things I’ve ever heard, and you make it sound like it’s normal or that other people experience that.’ And I remember just being like, oh, and that happened when I was older. That happened when I was in college. And that hurt a lot because I thought in college, I had started to build a group of people that I could work with or would understand me without making me feel that way. And it very severely put me back, I think. And so having someone I trusted do that, it makes it still a lot harder to ask for support moving forward.”

Other participants explain this as non-malicious and genuine misunderstandings. CiCi expressed this frustration as, “They don't always believe me and believe that the things that I attribute my feelings to are the things that actually may be causing my feelings.” These individuals commonly offered understanding for previous poor support by recognizing differences in their own emotional process from those of neurotypical communities. Rather than attempting the cognitive labor that bridging that gap would require, these participants largely decided that asking for support *and* educating the support provider was too much of a hassle. These participants largely expressed frustration with the lack of effort others have put towards understanding them. Winston did this by saying:

“I don't think people are good at reading between the lines. In our whole society, I think, is geared towards treating symptoms rather than treating the actual issue. So, at the end of the day, friends, family, myself, corporations, the whole universe is just okay... lets just pick this problem off. Rather than okay, you know, and even in school this kinda being an ADHD study, even in school... well you just need to focus. No one would take a step back and say okay, why is it that he never focuses? Y'a know. Why is it that he can start a sentence in one place and then ten minutes later, after this rambling, now we're in a completely different universe. The issue is always don't do that, don't be this way, or don't do this. But okay, what is the underlying issue?”

### ***I Am The Problem***

Many participants expressed that their greatest obstacle to receiving support was themselves. This functioned in two ways. First, participants identified the problem as them choosing to not ask for support even when they know it could be beneficial. Jimmy said, “I'm a little stubborn.” Some individuals make this choice out of pride, or shame. However, individuals making that choice under this theme have all identified making this choice because they believe *they* are the problem. Joy expressed frustration at this by saying:

“This is what the issue is. I'm thinking of 14 things at once. You're thinking of one thing at once, and you're getting mad at me for not thinking of only that one thing and switching around, get off my case. Just leave me alone. Let me do what I want to do.”



Participants explained that the stressors were either caused or exacerbated by something to do with their internal processing. Leo discussed the ways emotional dysregulation interrupts their cognitive flow during a stressor.

“I'm able to form good arguments for things. I'm capable of that. And when my emotions get the better of me, it's like, I can't do that anymore. And it's really frustrating because in the moment, I'm like, I can't think of the thing, and I know that I can think critically and do it well, but yeah. So it's a very frustrating and disheartening experience... I think if they could say something like, we're all obviously upset here, and let's take a minute to breathe, and we can revisit this in a minute, or, you know, giving me some sort of verbal, like, indication that, like, we can revisit this situation once people are feeling better and acknowledging that I'm not at my best. We all know that I'm not at my best, and we all know that I'm capable of better, but it's just not happening right now.”

### ***I Will Be a Burden***

This theme was extremely common among participants. Here, participants claimed that by receiving support that they would become burdens for their support providers. Elizabeth expressed this as:

“It actually took me, like, a couple of days to even tell them about it because I was just embarrassed. Really, It's a hard situation to talk about with people already. And I don't know, I feel like sometimes, too, I can also be an emotional burden on my support system.”

Consistently, participants expressing this sentiment framed it as an issue with their desires for support rather than the other's ability to fulfill those. Wanda did this by saying, “I feel like I'm setting too high of an expectation on people, even though it is the bare bit of them.” For many, this feeling of asking for too much prevents them from asking for anything at all. Reed explained his discomfort by saying:

“To come out of the gate and be like ‘this is how I'm feeling’ for some people that can be... that can catch them off guard. Not everyone is accepting of a directly vulnerable conversation. You kind of have to... I'd hate to take anybody hostage with my problems.”

### ***I Can Handle It***

Within this theme participants often lose out on support because they believe they are on their own to handle whatever the stressor is. In some cases this meant that individuals did not identify their need for support. Abby said, “A lot of times I won’t even realize I need it. So I won’t just ask for it. I’m going to shut the door.” More commonly, though, it manifested as an inability to find what they consider *useful* support. Wednesday explained:

“I usually don’t tend to ask for help or encouragement in anything because I know in the back of my mind that I kind of have to do it myself. What’s the point in asking for support? To bother someone else?”

Participants explained that this is especially true during moments of emotional dysregulation. In fact, some participants highlighted that having people address them during these moments, in any capacity, can actually elevate the negative effect. Annabelle explained this as:

“Most of the time when I have heightened emotions of anger or I’m upset or sad, having other people around me makes it worse almost. I don’t know what it is. It makes me more anxious. It makes everything worse. So I have to come back and have it quiet.”

### ***I Am Facing Practical Obstacles***

In this final theme, obstacles present themselves that are outside of the person. Many participants expressed difficulty finding support due to logical issues such as having a remote support network. Many of the participants expressed that their most trusted supporters were difficult to reach for several reasons. Jennifer said:

“I live about 6 hours away from any support system where I live... It is definitely an obstacle because you can only really reach them through FaceTime or through phone calls or text messages, which can be difficult because one, you’re not there physically with the person and two, you’re unable to reach them a lot of the time.”

Further, participants explained that a lack of information, particularly in regards to their ADHD, could be a cornerstone obstacle that has bled into the other obstacles that they have faced. One way this manifested for participants was as difficulty affording or connecting to a therapist. In many cases, this barrier can make access to resources (ie: medication, language, etc) all the more difficult. Even with access, the process can be overwhelming or intimidating to navigate. Elizabeth said, “I have insurance and I am trying to find a new therapist now, but I'm scared because I don't want to be told that it's free and then get another bill.” Vanessa, who was diagnosed in her adulthood, presented the following:

“I think that perhaps if I had been diagnosed when I was younger, that my coping mechanism may be a bit different or, like, anger wouldn't be the emotion that I go to first. Because when you're little and you're high performing. But on your report card you continuously get told she's a very good student, but she won't stay in her seat or she won't get talking. And you're in therapy off and on since the time you're eight because your parents are going through a horrible force, you'd think that maybe somebody, just somebody would have been like, bitch has ADHD.”

### **Summary**

This study explored the social support experiences of ADHD adults. This study was intentionally designed to allow participants to elaborate on their experiences with as much or as little detail as they felt comfortable sharing. As a result, participants spoke with details and nuance that could not have been produced through more restrained or quantitative means. For example, nearly all participants expressed the importance of procedural rules in the supportive process for them. While literature does exist that discusses this element of the supportive process, it is incredibly rare that this is at the forefront of discussion like it was among participants. Inherent to any quantitative research is the power to control for terms or ideas that participants have space to discuss. While normative assumptions can be useful in certain contexts, research in neurodiverse spaces should consider how those norms may be interrupted in

neurodiverse spaces. As neurodiverse folks rarely get to set the terms for dialogue in any context, I encourage researchers to pay special attention to how they frame these conversations in neurodiverse spaces.

## Chapter Three: Study Two

### Study Two Rationale

#### Support Gaps

Individuals are not always direct about or aware of the best type of support to meet their needs. This can lead to a mismatch between the support offered by a provider and the support desired by the recipient. When the recipient's desires or expectations for support are not perceived as being met by the provider, then a support gap has been created (McLaren & High, 2015; Xu & Burleson, 2001). An individual that receives *more* support than desired is considered *over-benefited*. An individual that receives *less* support than desired is considered *under-benefited*. This can be discussed in terms of an overall gap of support or discussed in terms of what an individual receives for each unique support type. This means that individuals may be over-benefited for one type of support but under-benefited in others.

These gaps in support, whether from an overabundance or lack of adequate support, have potentially negative consequences for the individual and for the relationship (Goldsmith, 2000, McLaren & High, 2015; Wang, 2019; Williamson et al, 2019). These consequences can include increased feelings of hurt, lowered self-esteem, and negative relational impacts among others. McLaren and High (2015) conducted a study to understand the difference between being over- or under-benefited in particular support types. They also recognized that the benefits or consequences to support gaps depend on the type of support. In their study, they found that being *over-benefited* was most consequential when an individual receives more informational support than they desire. They also found the highest degree of hurt stemmed from emotional and esteem support deficits. In general, being under-benefited has been found to lead to greater negative

consequences than being over-benefited. It is for this reason that this study will focus on the consequences of being *under*-benefited.

There are many possible causes for support gaps. Researchers have determined that for support to be effective it must be visible to the recipient (Chu et al., 2010; Priem & Solomon, 2015). Individuals who do not perceive support, even when that support is actually provided, experience the consequences of receiving only the support that they see as visible. Other scholarship argues that invisible support does not have the same consequences as visible support if it goes wrong, and therefore can be preferred at times (Bolger et al., 2000). ADHD adults who struggle with working memory and emotional dysregulation may find it particularly difficult to recognize support during moments of overwhelm. As individual's hyperfocus on situations in front of them they may struggle to see and comprehend the context surrounding it. This hyperfocus could also cause individuals to hyperfocus on bad support when it is visible. Further, executive dysfunction and amygdala overwhelm may create additional barriers to asking for desired support. During moments of emotional dysregulation, individuals experience elevated emotions where they do not feel in control of their output. ADHD adults going through this experience may also experience hyperfocus on the event; which can make recognizing the context of a stressor challenging. This context may present as an obstacle to directly communicating for the support an ADHD individual needs when facing stressors; and thus, result in support gaps.

### **Dominant ADHD Symptoms**

The lived experience of ADHD adults should not be thought of as only the most visible traits. ADHD adults each experience a myriad of symptoms intersecting with each other to form a unique cognitive and emotional landscape for each person. However, I am particularly

interested in understanding how some of the most common ADHD traits intersect with the social support process. This study focuses on three specific ADHD symptoms: emotional dysregulation (ED), hyperactivity, and inattention.

Emotional dysregulation is a highly under-understood experience that can be incredibly disruptive to the emotional process. Individuals who experience ED frequently experience extreme feelings of sensitivity and anger among other impulses (Bunford et al., 2014; Hirsch, 2018; Shaw et al, 2014). This symptom, in particular, may elevate the perception of support gaps as individuals experiencing this may have increased needs for support. Individuals experiencing ED may experience heightened rejection sensitivity (Benrossian, 2021). When rejection sensitivity is discussed this regards intense emotional pain stemming from the perception of rejection or criticism. This further increases the stakes for support providers that want to get support *right*.

Hyperactivity and inattention are commonly used to refer to two dominant subtypes of ADHD; though, both symptoms are generally present to some degree in all ADHD individuals. Hyperactivity largely describes impulsivity and high energy levels. This impulsivity make help individuals bounce back quicker from a stressor than their support network would be prepared for. Considering those without ADHD often describe this process as too fast or not grounded (Bodalski et al., 2018). Perhaps this will lead to support providers providing an overabundance of support to recipients due to falsely assuming a higher emotional need.

Inattention is generally describing difficulty with working memory or attention span. This symptom, specifically, may have an impact on what support recipients are able to recognize as visible. Someone with strong inattentive symptoms may perceive receiving less support than they actually are which could result in support gaps. Ultimately, all three of these factors may

have influence on the desires for support an individual may have. These factors may also influence the degree to which an individual is able even to perceive support that is offered to them.

### **Relationship Type**

Certainly there are consequences to experiencing support gaps in any type of close personal relationship. In this study, I am particularly concerned with the support gaps that occur during romantic relationships. This relationship type was selected for a few key reasons. First, scholars agree that maintaining healthy romantic relationships in adulthood can provide significant benefits to health and quality of life (Burleson, 2003; Wymbs et al., 2021). Second, romantic partners are generally the most important source of social support for those who are in committed relationships (Williamson & O'Hara, 2017). Third, ADHD adults and their partners frequently report trouble maintaining romantic relationships (Canu et al., 2014; Knies et al, 2021; Minde et al., 2003; Overbay et al., 2009; Pollock et al., 2017). Commonly, questions of neurodiverse relationships are framed through neurotypical relationship expectations. Rarely does research ask neurodiverse people what *they* need for their relationships to improve.

In general, ADHD individuals are often evaluated for their competency at meeting the supportive goals of others. In this study, however, I was interested in exploring the competence of relational partners in meeting the supportive needs of ADHD adults. Predictions for the results of this study were in-part informed by the results of Study One, which highlighted the unique understandings of and expectations for social support that ADHD adults possess. Predictions here were also inferred from research in psychology and neuroscience that have explored emotional responses from neurodivergent adults. Study Two is interested in how, if at all, those unique expectations are met for ADHD Adults. This leads me to the following three hypotheses:



*H1: The severity of ADHD symptoms (emotional dysregulation, hyperactivity, inattention) will increase the perception of being under-benefited in a) emotional support, b) esteem support, c) network support, d) informational support, and e) tangible support.*

*H2: Severity of ADHD symptoms (emotional dysregulation, hyperactivity, and inattention) will be positively related to hurt feelings.*

*H3: Support gaps (emotional, esteem, network, informational, and tangible) will partially mediate the relationship between emotional dysregulation and hurt.*

## **Study Two Methodology**

### **Participants**

Participants were recruited for a questionnaire hosted on Qualtrics. Participants were recruited using the platform Prolific. All participants were adults (18 years of age and older) that self-identified as experiencing ADHD. The Adult ADHD Self-Report Scale (ASRS v.1.1) was used as a screening measure to identify the presence of adulthood ADHD. This is a validated 18-item measure that contains two sections (Kessler et al., 2005). Part A screens for ADHD and contains six items. Individuals with a score of four or more on this section were identified as experiencing symptoms of ADHD. Part B contains 12 additional items that work with Part A to better understand the symptoms experienced.. For each item, respondents must indicate the frequency of which each item pertains to their feelings and behavior. Much research has supported this scale as an effective and reliable measure of adulthood ADHD (Adler et al., 2006; Adler et al., 2018; Hines et al., 2012; Stanton et al., 2018). This study uses part A as the intended screening mechanism and has further included part B to allow for discussion about the symptoms of ADHD. Any individual that indicated the prevalence of ADHD, either through the provided

scale or medical diagnosis, were chosen to participate in the study. Further, participants identified themselves to Prolific as having a romantic relational partner. This study choose to focus on romantic relationships to hopefully better understand the dynamics of these relationships for neurodiverse adults.

A total of 316 individuals started the questionnaire; however, 30 people were removed from the dataset before analysis. Of those removed, 14 people were removed because, although they provided some data, they did not complete enough of the questionnaire to provide usable data to test the hypotheses. An additional person was removed from the sample for failing to identify and describe a relational context, as they were instructed to do. Finally, 15 people were removed for failing one or more attention checks. The final sample consisted of 286 participants. Demographic information for the final sample, including age, gender, race, partner ADHD, geographic location, and more can be found in Table 3. The average time to complete this questionnaire was 25 minutes and 22 seconds ( $SD = 14$  minutes and zero seconds). Each participant was compensated \$4.00USD through Prolific for their time responding to the questionnaire.

## **Measures**

Descriptive statistics (e.g., means and standard deviations), internal reliability scores (e.g., McDonald's omega), and intercorrelations between the study's variables are provided in Table 4.

### ***Hyperactivity and Inactivity***

Hyperactivity and inactivity were both measured using parts A and B of the ASRS-V scale described above (Kessler et al., 2005). This scale works to identify the prevalence of hyperactivity and inactivity as ADHD symptoms experienced by participants. Participants

answered 12 questions on a Likert-type scale indicating how frequently they experienced each symptom over the past six months. Response options range from 1 = *Never* to 5 = *Very Often*. Example items from this scale include “How often do you have difficulty keeping your attention when you are doing boring or repetitive work?” and “How often do you feel restless or fidgety?” Items from this scale were averaged to indicate the presence of hyperactive or inattentive symptoms. For each set of questions, higher averages indicated a stronger presence of that symptom. No items were reverse-coded.

### ***Emotional Dysregulation***

Emotional Dysregulation (ED) was measured by using the Emotional Dysregulation Scale-Short (EDS-S). The EDS-S is a six-item measure that has participants utilize a Likert-type scale to indicate how true each statement is for their experience. Participants may select from 1 = *Not True At All* to 7 = *Absolutely True*. These items were summed together and then averaged. This total indicates the severity of ED symptoms, with higher numbers indicating higher severity of ED. Examples from the Emotional Dysregulation Scale-Short include “When I'm upset, I have a hard time understanding what I'm feeling. I just feel bad,” and “Emotions overwhelm me.” No items from this measure were reverse coded.

### ***Support Gaps***

To measure support gaps, this study utilizes a modified version of the Xu and Burleson's (2001) scale to measure experienced and desired levels of support. The original scale was written to evaluate support gaps for spousal relations. This project has expanded the language to include all romantic relational partners. This scale asks participants to score 35 items twice regarding their support experiences with their romantic partner: once in terms of desired support, and once in terms of experienced support. Examples from this scale include asking participants how much

they desire, “Telling you that they love you and feels close to you,” and “Taking you to see a doctor when you don't feel well.” Each item is scored on a Likert-type scale in accordance with how often participants first experience and then desire that type of support from that particular relational partner. The scale is designed to include seven items for each of the five support types. Support gaps were calculated by subtracting the desired support from their received support. Raw scores ranged from -4 to 4. Participants that had raw scores *over* 0 were identified as being *over-benefited* in that type of support. Participants that had raw scores *under* 0 were identified as being *under-benefited* in that type of support. No items were reverse coded.

Because this particular research project was interested in the impact of being under-benefited, this data had to be further prepared before analysis. For each type of support, participants that appeared over-benefited had their scores transformed into a zero to represent that absence of being under-benefited. Remaining participants all had raw scores indicating discrepancies that appeared as negative numbers. By taking the absolute value of each negative value, scores were then turned into positive numbers to utilize during data analysis. Each score indicates the degree to which an individual has been underbenefited by receiving less support than they desire for each support type. That is, higher scores represent being more under-benefited. These procedures have previously been used to calculate the magnitude of being underbenefited across support types (see McLaren & High, 2015).

### ***Hurt***

Hurt was assessed by using three previously utilized questionnaire items (McLaren & High, 2015; Vangelisti & Young, 2000). In these items participants were asked to indicate how much hurt, emotional pain, and emotional injury they experienced following a specific support event. Ratings ranged from 1 = *none of this feeling* to 10 = *a great deal of this feeling*. These

items were averaged together to create an overall score for the degree of hurt experienced by each participant. No items from this scale were reverse coded.

### ***Attention Checks***

Given that this project is geared towards communicating with a population that struggles with attention regulation, two attention checks were included in this questionnaire. These attention checks were placed into Likert scaled items and asked that participants select a particular item on the questionnaire to indicate that they were still paying attention. For example, one attention check stated, “I am still paying attention. Please select ‘Agree.’” Participants who selected any other option besides “Agree” were viewed as having failed the attention check. As previously noted, a total of 15 individuals were removed for failing at least one attention check.

### **Procedures**

Approval for this project was obtained by the lead researcher’s university’s institutional review board. After consenting to participate and completing the ADHD symptom questionnaire, participants were asked to describe a stressor as well as the initials of the romantic partner they expected to receive support from regarding this stressor. Although support gap questions are often asked generally (e.g., Xu & Burleson, 2001), it was important for this questionnaire to ask participants to recall a specific stressor and support provider. ADHD adults who struggle to allocate attention may take on an “out of sight, out of mind” mindset for processing their emotions (Shaw et al., 2014). Allowing them to connect the questions with a specific experience may help participants provide more accurate and insightful responses about their support experiences. Once the participant had this experience in mind, they then completed the remaining questionnaire items. Once complete, participants were thanked for their and compensation was deposited into participants’ Prolific accounts.

## Data Preparation

All analyses were conducted using IBM SPSS version 26. Before conducting the substantive analyses, the data was inspected for instances of missing data. Only 14 participants were removed for incomplete data. These participants were missing multiple items on one or more scales, which warranted their removal from the final sample. This final dataset had 46,904 potential data points, of which only 93 items went unanswered. This means that there was 0.2% missing data in the final sample. Thus, given the relative infrequency of missing data, instances of missing data were handled by imputing the mean. Internal reliability scores were calculated for variables measured using scales, and the results showed all scales had at least adequate internal reliability.

## Study Two Findings

H1a-H1e were tested using five multiple regressions—one per hypothesis. In each regression, the three predictor variables were emotional dysregulation, inattention, and hyperactivity. The first regression (H1a) tested whether these three variables predicted being under-benefited for emotional support. The model was significant,  $F(3, 282) = 2.93, p = .034, R^2 = .03$ , Adjusted  $R^2 = .02$ . Emotional dysregulation was the only significant predictor of being underbenefited in terms of emotional support ( $\beta = .21, p = .003$ ). Inattention ( $\beta = -.07, p = .37$ ) and hyperactivity ( $\beta = -.04, p = .54$ ) did not predict an underbenefited emotional support gap.

H1b tested whether the same three variables predicted being underbenefited in terms of esteem support. The overall model was significant,  $F(3, 282) = 2.76, p = .043, R^2 = .03$ , Adjusted  $R^2 = .02$ . The only significant predictor of being underbenefited regarding esteem support was emotional dysregulation ( $\beta = .18, p = .011$ ). Neither inattention ( $\beta = -.06, p = .45$ ) or

hyperactivity ( $\beta = .02, p = .75$ ) were significant predictors of being underbenefited for esteem support.

H1c tested whether the same three variables predicted being underbenefited in terms of network support. The overall model was not significant,  $F(3, 282) = 2.39, p = .07, R^2 = .03$ , Adjusted  $R^2 = .01$ . None of the predictors were found to be significant regarding being underbenefited in network support. Here, emotional dysregulation ( $\beta = .13, p = .08$ ), inattention ( $\beta = -.03, p = .73$ ) and hyperactivity ( $\beta = .07, p = .34$ ) were not significant predictors of being underbenefited for network support.

H1d tested whether the same three variables predicted being underbenefited in terms of informational support. The overall model was not significant,  $F(3, 282) = 1.69, p = .17, R^2 = .18$ , Adjusted  $R^2 = .01$ . None of the predictors were found to be significant regarding being underbenefited in informational support. Here, emotional dysregulation ( $\beta = .11, p = .12$ ), inattention ( $\beta = .03, p = .69$ ) and hyperactivity ( $\beta = .01, p = .89$ ) were not significant predictors of being underbenefited for informational support.

H1e tested whether the same three variables predicted being underbenefited in terms of tangible support. The overall model was significant,  $F(3, 282) = 3.81, p = .01, R^2 = .04$ , Adjusted  $R^2 = .03$ . Only emotional dysregulation ( $\beta = .22, p = .00$ ) was found to be significant regarding being underbenefited in informational support. Neither inattention ( $\beta = -.01, p = .87$ ) nor hyperactivity ( $\beta = -.03, p = .64$ ) were significant predictors of being underbenefited for informational support.

Overall, the results partially supported this set of hypotheses. Although inattention and hyperactivity did not significantly predict any underbenefited support gap, emotional dysregulation did predict being underbenefited in terms of emotional, esteem, and tangible

support. Of note, the effect sizes of the significant models and the beta coefficients for emotional dysregulation suggest a small effect of this variable on support gaps.

H2 stated that emotional dysregulation, inattention, and hyperactivity would positively associate with hurt. To test H2, a multiple regression was used in which emotional dysregulation, inattention, and hyperactivity were included as predictor variables and hurt was included as the criterion variable. The overall model was significant,  $F(3, 282) = 18.91, p < .001, R^2 = .17$ , Adjusted  $R^2 = .16$ . Emotional dysregulation was the only significant predictor of hurt ( $\beta = .33, p < .001$ ). Hyperactivity ( $\beta = .05, p = .45$ ) and inattention ( $\beta = .09, p = .18$ ) did not significantly predict hurt. H2 was partially supported.

H3 stated that support gaps would partially mediate the relationship between emotional dysregulation and hurt. Hayes PROCESS macro (Model 4), which tests for mediation, was used to test H3. The independent variable was emotion dysregulation, the five mediator variables were the underbenefited support gap scores for each of the five types of support, and the dependent variable was hurt. Z-scores were used for all variables in the analysis to obtain standardized coefficients in the output. Results showed a significant indirect effect of emotion dysregulation on hurt through the underbenefited support gap for tangible support only ( $\beta = .04$ ). There was also a significant direct effect of emotion dysregulation on hurt ( $\beta = .34, p < .001$ ), meaning that the previously reported indirect effect was a partial mediation. Figure 1 provides a visualization of the model, including beta coefficients for all paths in the model. Table 5 provides complete statistical results for the model. Overall, H3 was minimally supported, as only one underbenefited support gap (tangible support) yielded a significant indirect effect.



## **Summary**

This study was able to identify relationships between ADHD symptoms and support gaps. Out of the three symptoms analyzed, the only symptom to indicate a significant relationship was emotional dysregulation. Emotional dysregulation was also the only symptom to indicate a relationship with hurt. Future research should continue to explore the phenomenon of ED and how it intersects with the supportive process. Limitations to this study are explored in Chapter Four of this paper.

## Chapter Four: General Discussion

The overarching goal of this paper was to better understand the social supportive experiences of ADHD adults. ADHD adults often have their communication skills evaluated but rarely are given a platform to discuss their preferences, strategies, or understandings of social support. With this paper, I wanted to pass the metaphorical mic to neurodiverse individuals and allow them to discuss the social supportive process in their terms. This was accomplished through the use of two separate studies. Study One utilized qualitative interviews to explore the goals, preferences, and obstacles to social support for these adults. Study Two was included to add some context to the consequences of getting this support *wrong* by evaluating the presence and consequences of various support gaps.

Study One, specifically, aimed to explore the goals, preferences, and obstacles to social support that ADHD adults experience. Central to this research was the desire to offer a platform for these adults to define their emotional and supportive experiences in *their terms*. Through thematic analysis, I was able to identify common themes throughout each research question. Each theme interacts with and builds off of current communication and dis-ability literature.

RQ1 focused on ADHD adults' general goals for receiving social support. Consistent with current literature, many individuals identified the goals of validation, emotional coping or solvency (Burleson & Mortenson, 2003). Interestingly, however, ADHD adults also note seeking out support with the goal of *understanding*. These adults rely on their support network to help them cut out the noise and ground themselves in the reality they are facing. Although this type of support may not be enumerated in current communication scholarship, dis-ability researchers have long discussed challenges to understanding the ADHD individuals face (Bramham et al., 2009; Karalunas & Huang-Pollock, 2011). ADHD adults are commonly external processors, so

support networks that embrace and encourage this style of processing were recognized as helpful.

RQ2 explored *how* these people wanted social support communicated to them.

Participants placed their emphasis on procedural factors such as coordination. These adults recognized that support is a *process* and care deeply how that process is navigated. Current social supportive literature provides language to discuss these elements (Spitzberg, 2013); though, the importance of these factors are not commonly referenced in the general population. In part, this could be because the non-ADHD population may not experience strife having their procedural expectations met. Comparatively, these neurodivergent adults may have to vocalize these needs or differences more frequently (Mastoras et al., 2015). Further, this finding is supported by research that discusses ADHD adults ability to succeed in coping strategies when others are able to guide and support them in this process (Hagstrøm et al., 2020; Newark, 2010).

RQ3 sought to identify the common barriers to support for ADHD adults. Throughout four of the identified themes, participants identified barriers to *asking* for or deserving support. This is particularly interesting given its truth whether or not the individual was able to recognize their actual need for support. Consistently they framed their own obstacles in terms of barriers that others may face in supporting them properly. This seemed to be a manifestation of the fact that neurodivergent people are often asked to consider the expectations of others above their own needs (Stenning & Rosqvist, 2021). Further, as highlighted a number of times in this paper, neurodivergent individuals often have their communication strategies discussed as *bad* or *wrong* by general populations (Mastoras et al., 2015; Wymbs et al., 2015). In addition to threatening mental health outcomes, this internalized bias makes it difficult for these individuals to reach out even if they know they need to (Björk & Rönngren, 2020).

The goal of Study Two was specifically to better understand the support gaps experienced by ADHD adults in romantic relationships and their consequences. Evaluating this requires understanding three components: supportive desires, perceptions of support, and consequences of those perceptions. Gaps exist to indicate the discrepancies between those supportive desires and the perceptions of received support. Consequences, in this study, referred to the impact of those gaps on the well-being of the individual receiving support.

Results of this study support H1a, H1b, and H1e and by indicating a relationship between ADHD symptoms and (emotional, esteem, and tangible) support gaps. The results indicate a significant relationship between emotional dysregulation and the experiences of certain support gaps. As individuals have their cognitive and emotional experience shaped by ED, their perceived support gaps increase. This relationship was statistically significant in areas of emotional, esteem, and tangible support. However, the effect size from each of these was minor. Here, I have two possible interpretations of what is occurring: ED could cause individuals to want *more* from their support provider or could cause individuals to be more critical of the support that they do receive. Either interpretation is consistent with dis-ability research that recognizes that ED may drastically alter the emotional process for ADHD adults (Hirsch, 2018; Shaw et al., 2014).

H2 was also supported by the results of this study. In H2, only one of three ADHD symptoms that were tested showed a positive relationship with increased feelings of hurt. Specifically, only emotional dysregulation was found to have a statistically significant relationship with increasing feelings of hurt. This finding is again consistent with research that discusses the emotional consequences of experiencing ED (Hirsch, 2018; Shaw et al., 2014). ED heightens the emotional stakes for those experiencing it and can allow negative affect to

overwhelm processing centers (Bunford et al., 2014). Individuals experiencing ED find themselves experiencing elevated sensitivity to criticism which would tie closely to elevated feelings of hurt.

Finally, H3 was partially supported by the results of this study. H3 looked at the relationship between emotional dysregulation and hurt and asked whether or not various support gaps could partially mediate that relationship. Of these five types, only one support gap produced statistically significant results: underbenefited tangible support gaps. It is possible that this type of support gap was able to partially mediate the relationship due to ADHD adults' difficulty conceptualizing what is not visible (Karalunas & Huang-Pollock, 2011). In other words, perhaps when this support type was missing it was easier for individuals to notice.

No statistically significant relationships presented themselves for the other four support types. There are a few possible reasons for this. First, it is possible that no relationship exists between these variables. More likely, however, is that these variables are related in a different way than specifically hypothesized herein. Perhaps the model should have evaluated the relationship between support gaps and hurt by using emotional dysregulation as the partially mediating variable. Future researchers should consider this possibility and continue to explore how emotional dysregulation influences the supportive communication process.

## **Practical Implications**

### **ADHD Adults**

While many of these findings will help shape future research, there are several practical implications as it relates to ADHD adults. The first is that instead of looking away from ADHD and trying to *overcome* it, I encourage these individuals to look at their ADHD and try to *understand* it. Across the board participants discussed how helpful language about and

understanding of ADHD has been to improving their own emotional outcomes. While Study Two did not test this empirically, future researchers should consider designing a research project that evaluates this impact. In the meantime, however, ADHD adults and their support networks have a lot of unlearning to do if only to counter incorrect assumptions and biases that widely exist. ADHD does not inherit a life of discomfort or poor relational outcomes. Instead, ADHD does inherit a life met with external challenges built by a neurotypical culture (Stenning & Rosqvist, 2021). Neurodivergent people do *not* have the responsibility to change this culture in the masses, but I do encourage them to confront this bias within themselves. While barriers exist in terms of locating professional clinical help, resources continue to emerge into the public that helps to counter this. I encourage ADHD individuals to interact with these resources whenever available.

### **Support Providers**

In any supportive interaction the burden is on the support provider to achieve positive outcomes by meeting the needs of the support recipient (Burleson & Mortenson, 2003; High & Solomon, 2014; MacGeorge, 2010). This can prove particularly challenging in relationships where those needs are not communicated directly or may differ from expected desires. In relationships with ADHD adults, support providers may not receive direct communication asking for a particular type of support for several reasons. Across the board participants in this study recognized that support is a lot easier for them if they are not the one who has to initiate the process as it helps them avoid feeling like a burden on these networks.

I encourage support providers of neurodivergent individuals to take the initiative to check in on these friends, particularly during moments of known stress. I also encourage these individuals to *ask questions* rather than make assumptions. ADHD individuals may get

therapeutic benefit out of talking out their perspective regardless of support provided after the questioning period. Meaning, the pressure is less about providing a remedy for their stressors and more about offering them a platform for dialogue. Neurodivergent persons are used to being spoken *for*, so I encourage support providers to speak with them instead.

### **Implications for Researchers**

This study has highlighted several areas that future researchers should pick up on. While these are largely be discussed in this paper's section on limitations, it is important to note a few overarching implications for researchers regarding the overall process. Current literature works to differentiate between neurotypical and neurodivergent populations through primarily measuring *competence*. This paper has repeatedly highlighted the inherent dangers to this process. Rather than understanding deviations from normative behaviors as failures, I encourage researchers to put extra care into the language they use to discuss these matters. First, because the current expression of these findings does not present as a whole truth. There is not objective measure of competence; but instead, only standards set by normative behavioral patterns (Spitzberg & Cupach, 1984; Stenning & Rosqvist, 2021). Second, because this linguistic framing supports the damaging biases that exist in social culture. When a researcher takes pen to paper they are exercising power; I encourage them to use that power to confront misunderstandings instead of deepen them.

Other key takeaways from this project live in the content. First, ADHD adults in Study One consistently expressed the benefits of receiving support in *understanding*. In part they were referring to understanding their ADHD, but they were also largely referring to assistance breaking down their stressors and identifying their options. Future researchers should explore

what message features allow for this element of support without becoming a face threat to the individual's competence.

Next, future researchers should expand on how procedure rules in interactions may influence the social support process. Neurodivergent adults are rarely given the opportunity in research to set the terms for what constitutes successful support. For example, across the board, participants in this study expressed that one of the most important things support providers ought to consider is the *timing* of support. Rather than assuming an ADHD adult who initially steps away from a stressor is *harmfully* avoidant, perhaps stepping away allows them to be *productively* avoidant. Future researchers should explore the importance of procedural rules, such as timing, in the social supportive process particularly for neurodivergent adults.

Further, Study Two supported the importance of meeting needs of a support recipient. Study Two also affirmed that emotional dysregulation has a statistically significant relationship with hurt feelings. These reminders, especially in conjunction, should work to encourage researchers to explore the true impact of support gaps on ADHD adults. Current literature continuously shows many ADHD adults struggling with mental health and feelings of isolation. Future researchers should seek to understand the role that support gaps play in this experience and hopefully establish an understanding of support providers can work to combat this.

### **Limitations and Future Directions**

These study, like all others, are not without limitations. The first main limitation of Study One is based on the participant demographics. This study had only 20 participants that were interviewed during this study. Of this, the sample was overwhelmingly female and white. Future researchers should expand this conversation by recruiting a larger and more representative sample. While Study Two did not experience such a drastic skew in terms of gender, participants



were still overwhelmingly white. This may limit our understanding of exactly how support interacts with diverse populations. Future researchers should expand this understanding by doing their part to reach a more representative audience.

A second limitation exists in regards to the relationship type present in the study. Since Study Two was specifically looking at romantic partnerships, it is important to highlight that the vast majority of participants were in heterosexual relationships. Further, this study did not analyze whether or not partner neurodiversity impacted the supportive process despite recognizing its potential influence. Future researchers should consider how relational contexts like these may intersect with the social supportive process through intentionally recruiting a more representative sample.

A third limitation to this study was the broad scope at which Study One interviews were structured. At this stage, I believed that was necessary in order to truly explore the support process for neurodivergent people without placing structural assumptions onto them. Specifically in regards to preferences participants provided answers that pulled from multiple conversations in the literature. While this is a useful launching place, future research should work to flesh out some of these concepts. This could be done by creating a more specific interview protocol that guided the participant into one or two channels for discussion.

A fourth limitation of Study One is that individuals may not always be accurate when reporting data through interviews. At times this may occur because an individual may choose to omit certain details to the interviewer. Other times, this may occur when an individual is remembering something through a distorted lens. In these interviews, participants would offer somewhat contradictory responses when asked about support in and out of specific contexts. ADHD adults may struggle with conceptualizing supportive interactions and as a result exhibit a

form of dissonance when responding to questions. This is not to say that their responses are *false*, per se. Instead, there is likely a good divide between the way they process supportive encounters in the long-term and the way in which they actually experience it. This possibility was why this study made a point to offer both channels of dialogue rather than choosing one avenue exclusively. Future researchers should consider this as they structure their studies. While there is truth to this in all populations, ADHD adults experience heightened degrees of impulsivity and difficulty with working memory that may elevate this struggle. Future research could incorporate quantitative analysis to determine if this is a significant factor.

A fifth limitation of this study was that results from Study Two, even when significant, produced rather small effect sizes. While this was useful in terms of identifying patterns, it certainly warrants further investigation. Future research should continue to explore these ideas in larger and different populations to test the true generalizable significance.

A sixth limitation of this study is the narrow scope of ADHD symptoms discussed in Study Two. Study Two explored ADHD through analyzing three of many potential symptoms. Two of these, inattention and hyperactivity, are extremely broad in nature. Perhaps future research should look at more defined symptoms such as hyperfixation, impulsivity, etc. to determine whether or not patterns emerge.

## **Conclusion**

In this paper, I wanted to explore the social supportive experiences of ADHD adults. Study One offered the microphone to ADHD adults where they were able to explain the nuance of their supportive experiences. These perspectives offer a glimpse into what these adults may or may not find useful during the supportive process. Study Two explored whether or not these supportive desires were being met in romantic relationships and the emotional consequences if

they were not. This study showed that emotional dysregulation may, in fact, raise the stakes for support providers to get support *right* for these adults. Future research should, among many things, continue to explore how factors such as ED may alter these supportive preferences. is

## Appendixes. Relevant Information

### Appendix 1. Data

Table 1. Study 1: ADHD Adults' Demographic Information (N = 20)

	<i>n</i> (%)
Ethnicity <sup>1</sup>	
White	20 (100%)
Native American/Alaskan Native	1 (5%)
Race	
Hispanic	0 (0%)
Not Hispanic	20 (0%)
Gender	
Woman	11 (55.0%)
Man	7 (35.0%)
Non-Binary/Third Gender	1 (5.0%)
Transgender Woman	1 (5.0%)
Sexual Orientation	
Straight	10 (50.0%)
Bisexual	3 (15.0%)
Queer	3 (15.0%)
Pansexual	2 (10.0%)
Lesbian	1 (5.0%)
Prefer Not to Say	1 (5.0%)
Relationship Status	
Single / Not in a Committed Relationship	9 (45.0%)
Committed Dating Relationship	3 (15.0%)
Married	8 (40.0%)
Education <sup>2</sup>	
High school or equivalent	5 (25.0%)
Some college credit, no degree.	4 (20.0%)
Associate degree	1 (5.0%)
Bachelor's degree	6 (30.0%)
Master's degree	1 (5.0%)
Doctorate Degree	2 (10.0%)
Prefer not to answer.	1 (5.0%)

### Income<sup>3</sup>

\$0	0 (0.0%)
\$1 to \$9,999	0 (0.0%)
\$10,000 to \$24,000	4 (20.0%)
\$25,000 to \$49,000	6 (30.0%)
\$50,000 to \$74,999	6 (30.0%)
\$75,000 to \$99,999	0 (0.0%)
\$100,000 to \$149,999	1 (5.0%)
\$150,000 and greater	2 (10.0%)
Prefer not to answer / Not Sure	1 (5.0%)

### Employment Status

Full time employee (35+ hours)	12 (60.0%)
Part time employees (34 hours or less)	2 (10.0%)
Full time student	2 (10.0%)
Unemployed	1 (5.0%)
Self-employed contractor (Part time)	2 (10%)
Self-employed contractor (Full time)	1 (5.0%)

### Geographic Location

	1 (5.0%)
Arkansas	1 (5.0%)
Georgia	3 (15.0%)
Illinois	7 (35.0%)
Louisiana	3 (15.0%)
Missouri	2 (10.0%)
North Carolina	1 (5.0%)
Ohio	2 (10.0%)
Texas	

### Diagnosed Dis-ability Breakdown

Cognitive impairment	7 (35.0%)
Mental health impairment	5 (25.0%)
No diagnosis	8 (40.0%)

### Notes:

<sup>1</sup>Ethnicity sums to greater than 100% because one participant identified as two or more races or ethnicities.

<sup>2</sup>Highest level of education completed unless otherwise noted

<sup>3</sup>Income reported in \$USD

Table 2. Study 1: Examples of Interview Questions

Research Question:	Interview Question:
What goals for receiving social support do ADHD adults have?	When the stressor presented itself to you, what did you want out of your interactions with your support network?
What are the preferences of ADHD adults when receiving social support?	What could the people in your life have done to provide better support to you in this context?
What are the common obstacles to receiving support for ADHD adults?	Why do you think the support that was provided to you either worked or failed?

Table 3. Study 2: ADHD Adults' Demographic Information (N = 286)

	<i>n</i> (%)
Ethnicity <sup>1</sup>	
White	201 (70.3%)
Latinx/Hispanic	56 (19.6%)
Black/African American	17 (5.9%)
Asian	15 (5.2%)
Native American/Alaskan Native	1 (0.3%)
Native Hawaiian/Pacific Islander	1 (0.3%)
Mixed Race (Did Not Specify)	1 (0.3%)
Another Racial Background	5 (1.7%)
Prefer Not to Answer	1 (0.3%)
Race	
Hispanic	68 (23.8%)
Not Hispanic	216 (75.5%)
Did not answer	2 (0.7%)
Gender	
Woman	141 (49.3%)
Man	132 (46.2%)
Non-Binary/Third Gender	9 (3.1%)
Transgender Woman	3 (1.0%)
Questioning	1 (0.3%)
Sexual Orientation	
Straight	185 (64.7%)
Bisexual	58 (20.3%)
Pansexual	13 (4.5%)
Lesbian	9 (3.1%)
Gay	6 (3.1%)
Queer	6 (3.1%)
Asexual	3 (1.0%)
Prefer Not to Say	3 (1.0%)
Demisexual	3 (0.7%)
Trans Amorous	1 (0.3%)
Relationship Status	
Committed Dating Relationship	200 (69.9%)
Engaged	18 (6.3%)
Married	62 (21.7%)
Not in a Committed Relationship	4 (1.4%)
Divorced/Separated	1 (0.3%)
Prefer Not to Say	1 (0.3%)

## Education<sup>2</sup>

Did not complete high school	4 (1.4%)
Some college credit, no degree.	59 (20.6%)
High school or equivalent	33 (11.5%)
Trade, Technical, or Vocational Training	22 (7.7%)
Associates degree	18 (6.3%)
Bachelor's degree	103 (36.0%)
Master's degree	43 (15.0%)
Doctoral degree (PhD)	3 (1.0%)
Professional degree (e.g., JD, MD, DDS)	1 (0.3%)

## Income<sup>3</sup>

\$0	4 (1.4%)
\$1 to \$9,999	33 (11.5%)
\$10,000 to \$24,000	66 (23.1%)
\$25,000 to \$49,000	72 (25.2%)
\$50,000 to \$74,999	33 (11.5%)
\$75,000 to \$99,999	31 (10.8%)
\$100,000 to \$149,999	24 (8.4%)
\$150,000 and greater	9 (3.1%)
Prefer not to answer/Not Sure	14 (4.9%)

## Employment Status

Full time employee (35+ hours)	131 (45.8%)
Part time employees (34 hours or less)	50 (17.5%)
Full time student	51 (21.3%)
Part time student	18 (6.3%)
Self-employed contractor (Part time)	22 (7.7%)
Self-employed contractor (Full time)	11 (3.8%)
On paid disability	6 (2.1%)
Stay at home parent	2 (0.7%)
Retired	1 (0.3%)
Unemployed	25 (8.7%)
Another job status	1 (0.3%)



Geographic Location <sup>4</sup>	126 (44.2%)
North America	126 (44.2%)
Europe	7 (2.5%)
Australia	11 (3.9%)
Africa	6 (2.1%)
South America	9 (3.2%)
Prefer Not to Say	
Diagnosed Dis-ability Breakdown	
Sensory impairment	13 (4.5%)
Mobility impairment	9 (3.1%)
Cognitive impairment	78 (27.3%)
Mental health impairment	64 (22.4%)
Another diagnosis	10 (3.5%)
Partner ADHD	
Yes	69 (24.1%)
No	175 (61.2%)
Unsure	42 (14.7%)

*Notes.*

<sup>1</sup>Ethnicity/race sums to greater than 100% because some participants identified as two or more races or ethnicities.

<sup>2</sup>Highest level of education completed unless otherwise noted

<sup>3</sup>Income reported in \$USD

<sup>4</sup>In total, participants reported living in 21 different countries. The majority of participants either lived in North America or Europe, with the most frequently reported place participants lived with the United States ( $n = 79$ ). Although the majority of participants lived in Europe, the most frequently reported place that participants lived was the United States ( $n = 79$ ). Participants living in the United States reported living throughout 30 different states.

Table 4. Descriptive Statistics and Intercorrelations of the Study's Variables

Variable	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Emotional Support Gap	--	0.65**	0.46**	0.39**	0.50*	0.03*	-.04	-0.02	0.08
2. Esteem Support Gap		--	0.46**	0.48**	0.52**	0.02	0.03	0.03	0.02
3. Network Support Gap			--	0.45**	0.45**	0.12	0.06	0.09	0.20*
4. Informational Support Gap				--	0.46**	0.03	0.08	0.08	0.08
5. Tangible Support Gap					--	0.94	-0.02	0.03	0.17*
6. Emotional Dysregulation						--	0.50**	0.46**	0.37**
7. Inattention							--	0.51**	0.28**
8. Hyperactivity								--	0.25**
9. Hurt									--

Notes. \*  $p < .01$  \*\*  $p < .001$  (two-tailed).

Table 4 (Continued)

Variable	<i>M</i>	<i>SD</i>	$\omega$	Range
Emotional support (desired)	4.00	0.71	0.81	1.14 – 5.00
Emotional support (experienced)	3.83	0.85	0.89	1.00 – 5.00
Emotional support (gap)	.80	0.57	--	0.00 - 4.00
Esteem support (desired)	3.55	0.84	0.85	1.00 – 5.00
Esteem support (experienced)	3.47	0.88	0.89	1.00 – 5.00
Esteem support (gap)	0.87	0.78	--	0.00 – 4.00
Network support (desired)	3.02	0.82	0.87	1.00 – 5.00
Network support (experienced)	2.80	0.87	0.88	1.00 – 5.00
Network support (gap)	0.72	0.66	--	0.00 – 4.00
Informational support (desired)	3.29	0.80	0.86	1.14 – 5.00
Informational support (experienced)	3.24	0.87	0.89	1.00 – 5.00
Informational support (gap)	0.72	0.69	--	0 – 3.57
Tangible support (desired)	3.52	0.79	0.82	1.00 – 5.00
Tangible support (experienced)	3.45	0.87	0.85	1.00 – 5.00
Tangible support (gap)	0.84	0.74	--	0.00 – 4.00
Emotional Dysregulation	4.98	1.26	0.94	1.00 – 7.00
Inattention	6.69	2.04	0.83	0.00 – 9.00
Hyperactivity/Impulsivity	3.43	0.66	0.79	1.11 – 4.89
Hurt	5.43	2.30	0.87	1.00 – 10.00

Support gaps are absolute values

$\omega$  = the internal reliability statistic McDonald's *omega*.

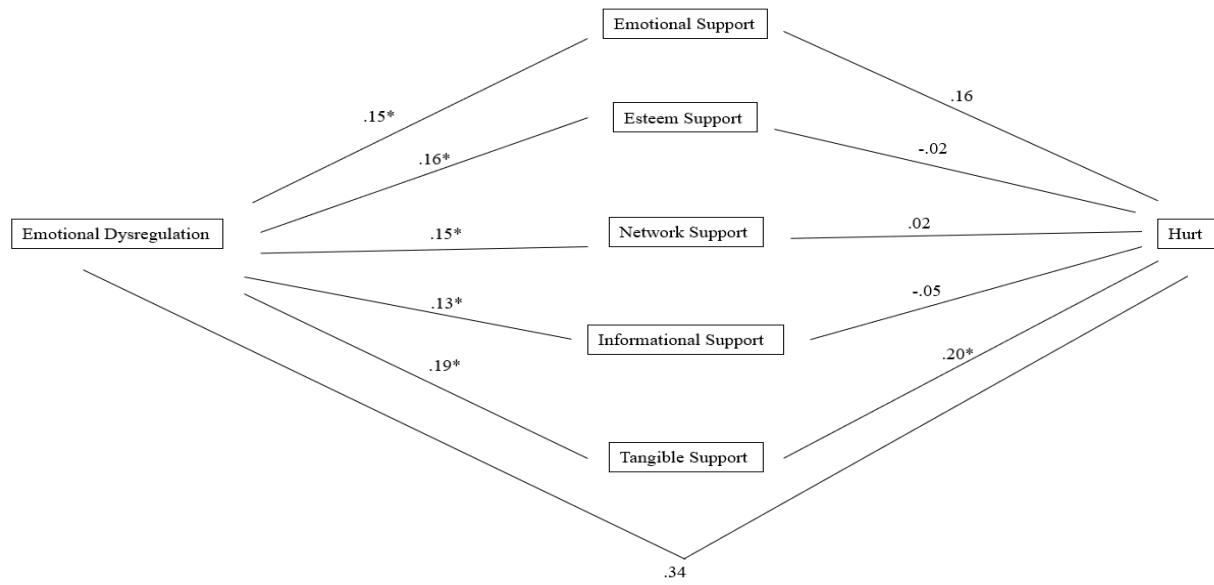
Table 5. Standardized Regression Coefficients and Bootstrapping Tests of Five Underbenefited Support Gaps as Parallel Mediators of the Relationship Between Emotion Dysregulation and Hurt.

Mediator Variable (MV)	Standardized regression coefficients		95% CI for indirect effect		
	ED-MV effect	MV-Hurt effect	Indirect effect	Lower limit	Upper limit
Underbenefited Emotional Support Gap	.15*	.16	.03	-.00	.07
Underbenefited Esteem Support Gap	.16**	-.03	-.00	-.04	.03
Underbenefited Network Support Gap	.15*	.02	.00	-.02	.03
Underbenefited Information Support Gap	.13*	-.05	-.01	-.03	.01
Underbenefited Tangible Support Gap	.19**	.20**	.04	.01	.07

*Notes.*  $N = 286$ . \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$ . ED = Emotion Dysregulation. MV = Mediator Variable. All support gaps estimates are standardized regression coefficients based on 5000 resamples drawn from our original sample.

## Appendix 2. Figures

Figure 1. Study 2: Hypothesis 3 Model



### **Appendix 3. Scripts**

#### **Script 1. Study 1 Interview Script**

Thank you for your interest in participating in this study. Before we get started, I'd like to go over the consent form with you. This will take just a few minutes. The purpose of this research project is to understand the social support experiences of ADHD adults.

One risk is the inadvertent release of information from the questionnaire or interview. However, every effort will be made to maintain the confidentiality of your study records. In a minute, I will ask for your consent to audio-record this interview. These audio files and any transcriptions will be kept in a secure OneDrive server which only the investigators have access to and any identifiable information that is collected will be disassociated from the data set as soon as data collection concludes. You will not be asked to provide any identifying information beyond basic demographic information, and we ask that you not provide personally identifying information when responding to any open-ended questions. A second risk is that you may experience potential feelings of discomfort from questions regarding potentially stressful or difficult situations.

Some questions may elicit emotional responses. If you experience this and need mental health services, you can call the National Mental Health Crisis Hotline at 9-8-8. You can also text HOME to 741741 to be connected with a mental health counselor via text message. The study will yield valuable information about how ADHD adults desire, experience, and receive social support.

If you have any questions, concerns, or comments, please direct them to Colter Ray, assistant professor ([colterray@lsu.edu](mailto:colterray@lsu.edu)) or Lindsay Duede, masters student ([lduede1@lsu.edu](mailto:lduede1@lsu.edu)). All participation will occur online. At this point, you have already completed our pre-screening survey. This follow up interview will last around 30 minutes, though it can run longer or shorter depending on how much information you choose to provide. No more than 100 participants will be interviewed during this study.

To participate, you must be an adult (18 years of age or older) and fluent in English. Participants must also self-identify as being an ADHD adult. Those who are not 18 years of age or older or who are not fluent in English cannot participate in this study. Participants that do not

show or indicate the presence of ADHD are also not permitted to participate in this study. Do you meet this criteria?

[WAIT FOR VERBAL YES]

Right to Refuse: Participants may choose not to participate and may withdraw from the study any time without penalty or loss of benefit to which they might be entitled. Results of the study may be published, but no names or identifying information will be included in the publication. Subject identity will remain confidential unless disclosure is required by law. We will ask for identifying information but this data will be removed from the dataset after data collection occurs. This study has been approved by the Louisiana State University IRB. For questions concerning participant rights, please contact the IRB Chair, Dr. Alex Cohen, 225-578-8692 or [irb@lsu.edu](mailto:irb@lsu.edu). Do You Consent to Participate in this Study?

[WAIT FOR VERBAL YES]

Great. Now, can I audio record this interview?

[WAIT FOR VERBAL YES BEFORE HITTING RECORD]

### **Pseudonym Question**

Great, let's get started. First, I'd like to give you the opportunity to choose your pseudonym. Or, I can choose a pseudonym for you. Is there a pseudonym you would like to use?

[PARTICIPANT CHOOSES PSEUDONYM]

Great, thank you. I'd like to start by exploring what some of your general goals and expectations for receiving support from your network are. For this section you can think about support broadly. Support could include someone helping you emotionally cope, helping you solve a problem, providing you with information and resources or anything else you feel is relevant.

Whenever I use the term "stressor" I am simply referring to an event or circumstance that has caused emotional or physical strain. Remember, this section is not tied down to any specific event, so feel free to elaborate as you see fit.

1. How would you generally describe your emotional state when facing a stressor?
2. In general, what would it mean to you to receive *good* support from others?
3. When facing a stressor, how (if at all) do *you* typically want to address it?
  - a. When facing a stressor, how (if at all) do *you* typically want to address it?
  - b. Are you generally aiming to solve the problem, cope with it, or something else?

4. With that goal in mind, what does it mean to receive *good* support from others?
  - c. What types of actions or words do you find yourself wanting from your support network?
5. Do you typically find yourself asking directly for the support you'd like?
  - d. If no - why not?
  - e. If yes - how?
6. How would it have made you feel if the response to you going through a stressor was for that person to offer you support by:
  - f. Offering you a tangible gift?
  - g. Providing you advice or information?
  - h. Connecting you with someone else who has faced a similar stressor?
  - i. Communicate that they care for you, are concerned, and/or that they love you?
  - j. Offering you words of affirmation such as reminding you that they believe in you or other things that build up your self-esteem?
  - k. Attempting to distract you from the stressor?
  - l. Giving you physical affection such as a hug or pat on the back?

Great, so we just spoke about what you generally expect from your social network. Now I'd love to learn a bit more about the support that they actually provide to you. For the next set of questions, let's go ahead and contextualize them to a specific stressor. To start, can you share with me a bit about a recent stressor?

[Participant shares stressor]

Great, thank you! Please keep the context of this stressor in mind as we move into the next series of questions.

7. During *this* stressor, did you directly reach out to anyone for support? Why or why not.
8. What did your support providers say or do that was helpful?
  - m. What did they say or do that was unhelpful or hurtful?
9. How did you feel after they offered you that support?
  - n. Have those feelings changed overtime?
10. Earlier, you said that your goal for dealing with a stressor was \_\_\_\_\_. Would you say that the support you received helped you reach that goal?
  - o. If so, how?



- p. If not, why not?
11. Did you experience any obstacles accessing support?
- q. If yes: What were they?
    - i. Is there anything your network could have done to help you overcome those obstacles?
12. At any point, did you find yourself experiencing elevated emotions that made it difficult to control your speech or actions? In other words, did your emotions ever “get the best of you?”
- r. [If yes] Can you elaborate a bit about what that experience felt like?
    - ii. During that time, what (if anything) did your support network do that helped or hurt?
13. What was the recovery process like for you? In other words, how (if at all) were you able to ‘re-bound’ from the stressor?

Thank you for sharing! Now that we’ve established what you *wanted* and what *actually happened*, the next few questions are a chance to reflect a bit more on that process.

14. Picking up on what we were just talking about, is there anything that could have helped you feel more in control of your emotions during a stressor like this?
15. Why do you think the support that was provided to you either worked or failed?
16. What could the people in your life do to provide better support to you?
17. Are there any common obstacles you experience in terms of receiving support?
- s. If yes: What are they?
    - iii. Is there anything your network could do to help you overcome those obstacles?
18. Is there anything else you want to share with me today?

Great, thank you so much for participating in this interview!

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## **Vita**

Lindsay Duede is an educator and an advocate from Springfield, Missouri. She earned Bachelor's Degrees in Political Science and French Language from Drury University. Following graduation, Lindsay relocated to Washington, D.C. where she worked as a campaign and fundraising consultant for various campaigns. In the summer of 2021, Lindsay decided to go back to academia and pursue a Master's Degree in Communication Studies at Louisiana State University. Here, Lindsay has studied Interpersonal Communication with a focus on social support and neurodiverse communication strategies. Throughout these experiences Lindsay has also been a fierce debate competitor and has earned five national titles in the International Public Debate Association: including two at the Professional level. Lindsay uses her background in campaign work and forensics to establish classroom dynamics that encourage deliberation and active participation. Following the completion of her MA, Lindsay plans to continue her studies with a PhD here at LSU.