# TITLE: Navigating residual diagnostic categories: The lived experiences of women diagnosed with autism and ADHD in adulthood

## ABSTRACT

This article conceptualises a combined autism and ADHD (AuDHD) diagnosis as a residual category not formally represented in diagnostic systems, addressing a critical gap in neurodiversity research. Using Interpretative Phenomenological Analysis of email interviews with six women diagnosed in adulthood, it examines the ambivalence arising from inhabiting this liminal diagnostic space. Residuality generates conflicting feelings about autism, ADHD, and the self, resulting in fragmented identities shaped more by societal narratives than by interpersonal perceptions. Themes include the contradictions between autism and ADHD ("two separate parts of my brain"), their sometimes-complementary relationship ("two sides of the same coin"), and the tension between neurodiversity and medicalisation narratives ("autism is a part of me, ADHD is an add-on"). To resolve this ambivalence, participants sought an objective understanding of their conditions and distinguished between neurodivergent and neurotypical identities. Collectively, their narratives reveal a fluid and dynamic understanding of AuDHD.

As the first study to explore the lived experiences of adults diagnosed with both autism and ADHD, it makes an original contribution by developing an AuDHD phenomenology and analytical framework. By amplifying the voices of women historically marginalised, the findings underscore the need for integrated diagnostic processes and tailored support to foster cohesive self-identity. This article contributes to neurodiversity literature, broadens understandings of categorical systems, and illuminates the complexities of navigating residual diagnostic spaces.

## KEYWORDS

**Diagnosis; gender; ADHD; autism; adulthood; co-morbidity; ambivalence**

## INTRODUCTION

> *Daily life is like a constant battle between my single-track mind and the myriad of jumbled thoughts in my brain. I can be so frustrated with myself, for example, when I lose my earbuds for the Nth time (ADHD) but I need them to regulate (autism)… A lot of the time I feel like a contradiction within myself.* (Meredith)

This article delves into the complex narratives of women[1], such as Meredith, living with the combined adult diagnoses of autism and Attention Deficit Hyperactivity Disorder (ADHD), describing "the stories that don't fit into the right 'just so' categories" (Star and Bowker, 2007: 273). Currently, autism and ADHD are defined separately in the fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual (APA,

---

[1] Note: Although one participant identified as genderqueer, they were comfortable being included under the term "women" due to their sex and gendered socialisation during upbringing.

2013), but this article depicts a joint diagnosis of autism and ADHD (AuDHD) as a 'residual category'. Interpretative phenomenological analysis reveals the experience of inhabiting a residual category, here presented as ambivalence in women's AuDHD narratives, with their simultaneous conflicting feelings and thoughts over the contradictory or complementary interactions between autism and ADHD; the interplay between the conditions and the self, whether these are part of their identity or separate from the self; and the validity of diagnostic categories. Participants' ambivalence reflects tensions between broader societal narratives that rationalise autism and ADHD - the medical and neurodiversity models. Findings challenge the inflexibility of current diagnostic systems, highlighting the need for nuanced and integrated approaches to assessment and post-diagnostic support to reduce ambivalence while fostering cohesive self-identity. This article makes an original methodological contribution to literature that re-stories neurodiversity from within (Murray et al., 2023; Bertilsdotter Rosqvist et al., 2023a) and autistic phenomenology (Murray, Lesser and Lawson, 2005; Milton, 2020) by developing an AuDHD phenomenology that centres the lived experiences of autistic ADHD women and applies an AuDHD frame of analysis.

### ***ADHD and autism, the medical model and neurodiversity***

ADHD and Autism Spectrum Disorder (ASD) are defined by the DSM-5 as neurodevelopmental disorders impacting individuals from childhood (APA, 2013). ADHD is characterised by persistent inattention, hyperactivity, and impulsivity, while autism involves challenges in social interaction, communication, and repetitive behaviours (APA, 2013). Before 1992, a diagnosis of autism required a learning disability (Cilia Vincenti et al., 2023), with a combined diagnosis of autism and ADHD only possible from 2013. Between 30-80% of those diagnosed with ADHD are also autistic, with a significant correlation between the two conditions (Hours et al., 2022). Recognition of ADHD's persistence into adulthood is recent, reflecting the DSM's unstable and ever-changing status (Jutel, 2009). Nevertheless, the manual fixes the status of conditions, confirms medical authority, and provides an illusion of scientific certainty (Bell et al., 2024).

Critiques of the DSM highlight its cultural relativism, disconnection from lived experience, and deficit-focused definitions (Jutel, 2009). The construction of ADHD and autism within a medicalised paradigm gathers behavioural 'symptoms' into diagnostic categories. Medicalisation refers to the process of defining, understanding, and treating previously nonmedical issues in medical terms (Zola, 1972; Conrad, 1975), which critics argue pathologises naturally occurring differences between individuals (Tekin, 2011; Rafalovich, 2005; Conrad, 1975; Kokanovic, 2013).

The neurodiversity paradigm, which emerged in the late 1990s, challenges the medicalised perspective by asserting diversity as inherent to humanity (Milton, 2020). Individuals with neurological differences are 'neurodivergent' and face structural barriers in a neurotypical-designed world (Milton, 2020). Shared community knowledge and the redefining of both conditions reveal the limits of diagnostic categories and how individuals and groups can subvert and reclaim them. Endeavours to de-medicalise autism have seen considerable success within the neurodiversity movement and there is an emerging phenomenon reconceptualising ADHD as a neurological difference rather than a disorder, akin to Critical Autism Studies (Bertilsdotter Rosqvist et al., 2023a; Huijg, 2020; Basten, 2023). Even when not considered a disorder, ADHD is often 'treated' with medication.

Epistemological uncertainty is intrinsic to diagnostic practices, particularly concerning mental 'disorders' and neurodevelopmental conditions (Fox, 2000; Williams and Calnan, 1996). ADHD has a history of uncertainty among clinicians and patients due to the lack of objective tests and scepticism towards its validity and treatment (Rafalovich, 2005). Reflecting both the medicalised DSM narrative and the neurodiversity movement's characterisation of autism as difference, Turowetz (2023) presents clinicians oscillating between different narratives dependent on context, rather than being solely tied to the medicalised narrative.

### *AuDHD as a residual category*

A residual category is what remains once a classification system is established. Focusing on chronic illness, Star and Bowker (2007) outline how residual categories emerge and their silencing effects. A category may become residual by embodying two or more categories or falling between cracks in the schema, as was the case with autism and ADHD before 2013. Similarly, a category becomes residual due to an overly rigid classification structure distinct from lived experience, becoming too complicated to describe and straining the limits of categorisation by the fluidity of its knowledge not fitting the established system.

Bowker and Star (2000) use the term "torque" to describe the tension arising from the disconnect between individual experiences and classification systems. This can be both harmful and beneficial for challenging the rigidity of classification systems, as demonstrated by the neurodiversity movement. Participants' experiences of seeking a combined diagnosis of autism and ADHD demonstrate torque. The diagnostic journey begins with questioning the possibility of, usually, one diagnosis. This questioning is triggered by close relatives or friends being diagnosed, or by researching a range of conditions in pursuit of an explanation for one's struggles. However, this period is marked by uncertainty and complicated by the presence of both autism and ADHD, with participants not fitting neatly into one category or the other:

"*But it didn't quite add up"* (Meredith)

*"But there were still gaps and things that didn't square with just being autistic"* (Chloe)

*"But I knew it wasn't the full story"* (Juliette)

Comparable to how bisexuality became a residual category by falling outside of the hetero/homosexual binary (Taylor and Bruckman, 2024), AuDHD fills a residual category existing across and between existing definitions of autism and ADHD.

### *Contextualising AuDHD: Emerging research on multiple neurodivergences*

Research has begun to explore the experiences of autistic individuals diagnosed in adulthood (Lilley et al., 2021; Kelly et al., 2022) and adults with ADHD (Redshaw and McCormack, 2022). This emerging literature includes research by neurodivergent scholars such as Bertilsdotter Rosqvist et al. (2023a, 2023b) who highlight structural barriers and alternative ways of working for neurodivergent individuals, including AuDHDers, in higher education.

Despite this progress, research explicitly focused on AuDHD remains underdeveloped. A limited number of studies include AuDHD participants, such as Chadwick et al.'s (2022) exploration of animal-assisted interventions for young people with ASD/ADHD diagnoses and Hedlund and Jordal's (2024) research about the working-life experiences of nurses with ADHD and/or autism. However, most studies do not distinguish between participants in relation to their conditions and contributions. They do not focus on the interaction between autism and ADHD or theorise AuDHD, leaving a gap in knowledge. My research (Craddock, 2024a; 2024b) was the first, to my knowledge, to explore women's lived experiences of combined ADHD and autism diagnoses.

Emerging recognition of the need to study multiple neurodivergences is evident in recent initiatives. The National Institute for Health and Care Excellence NICE guidelines for ADHD, for instance, acknowledge the importance of considering co-occurring neurodivergence, recommending slower medication titration for individuals with both ADHD and autism. This article makes a significant and original contribution to the emerging body of literature that considers the interplay between neurodivergent identities by centring the lived experiences of women with combined autism and ADHD diagnoses. Theorising AuDHD as a residual category, it explores the research questions:

- *What is it like to be a late-diagnosed woman with autism and ADHD?*
- *How do late-diagnosed women with autism and ADHD make sense of their diagnoses and experiences of both conditions?*

## METHODS

This study utilised Interpretative Phenomenological Analysis (IPA) due to its focus on delving deeply into subjective experiences to unveil nuanced meanings and individuals' sense-making processes (Smith et al., 2022). Being iterative and reflexive, IPA accentuates the uniqueness of each participant's viewpoint and amplifies marginalised voices, as demonstrated in earlier studies on autistic experiences (Howard et al., 2019; MacLeod, 2019).

Originally rooted in philosophy, phenomenology aims to study consciousness and translate the essence of experiences. Heidegger progressed phenomenology into interpretation, adopting an intersubjective stance (Smith et al., 2022). Smith's IPA built on Heidegger to comprehend experiences within individuals' worldviews and their attempts to derive meaning from them. IPA is idiographic - delving deeply into particulars - and interpretative - recognising the double hermeneutic process between researcher and participant (Smith et al., 2022).

Autistic sensory experiences are integral to the phenomenology of autism but were only acknowledged in the DSM-5 (APA, 2013), reflecting a historical prioritisation of observed social-communication and behavioural traits over autistic individuals' lived experiences (Murray et al., 2023). In response, neurodivergent researchers have developed autistic phenomenology, emphasising internal experiences and generating alternative frameworks like monotropism and bottom-up processing, which highlight how autistic individuals focus attention and process sensory information (Murray, Lesser and Lawson, 2005; Milton, 2020) . Similarly, ADHD researchers have re-storied ADHD as differences in intensity, variable and interest-based attention (Bertilsdotter Rosqvist et al., 2023a; Basten, 2023). Building on these perspectives, my research makes an original methodological contribution: the development of an AuDHD phenomenology that centres the lived experiences of autistic ADHD women.

### Sampling

The study applied a purposive sample of six participants, recruited through online platforms including Twitter, Facebook, and mailing lists. Selection criteria included UK-based females who had received both ADHD and autism diagnoses in adulthood. While modestly sized, the sample aligns with IPA principles emphasising data richness over quantity for thorough analysis (Smith et al., 2022).

### Participant Characteristics

Participants, aged 34 to 55, were all white. Two held PhDs, two were unemployed, and four were employed full time. Two identified as working class, four as middle class, two as bisexual, and four as heterosexual. Four were single, two in relationships or married, and three had children. Participants received diagnoses six months to three years before the study, with diagnoses evenly split between the NHS and private healthcare, reflecting barriers in NHS access.

Individuals who fall outside established category schemes become invisible or appear “only in a [sic] myriad fragments” (Star and Bowker, 2007: 273). Examining shared meaning across multiple narratives can unify experiences but risks fragmenting individual stories. Reconstructed narratives are included to minimise fragmentation and contextualise findings. However, it is important to note that the researcher shapes this, offering an organised compendium of participant accounts over real-life complexity. Narrative length is dependent on the detail participants shared.

## Data Collection

Semi-structured email interviews conducted by the author provided participants with a platform to freely express their experiences. Non-participant AuDHD women collaboratively developed and pilot-tested the interview guide (see supplementary material), covering topics related to women's experiences of comorbid ADHD and autism, diagnostic processes, post-diagnostic experiences, and identity. This collaboration, though less structured than formal advisory groups, reflects my ADHD-informed, organic approach, akin to public-patient involvement initiatives. Their input led to refinements in question wording to enhance clarity. As the project was unfunded, financial compensation was not possible. However, the relationship was reciprocal, with the researcher providing feedback on their academic work and writing for other projects. Participants could receive questions all together or consecutively, allowing flexible, inductive exploration through tailored questioning.

Using written communication facilitated reflection and minimised social and speaking barriers, which research with autistic and marginalised groups indicated was preferable (Benford and Standen, 2011; Ayling and Mewse, 2009). Transcripts ranged from 11 to 135 pages, demonstrating diverse responses and one limitation of email interviews; the necessity of additional researcher contact and follow-up.

## Data Analysis

IPA requires analysing each transcript individually. Transcripts were read multiple times to glean initial impressions before making detailed exploratory notes based on semantic content and language use (Smith et al., 2022: 86) as with "Finding a gym class that works for me – suited to my ADHD brain" and "'my ADHD brain' - suggests it is separate to herself". These notes were condensed into experiential statements, capturing participants' words and researcher interpretations (Smith et al., 2022), such as "I knew deep down that I was autistic but needed external validation". Connections between statements were mapped, forming participant-specific Personal Experiential Themes (PETs) with descriptive titles like "Life, in all honesty, has been a bit of a roller coaster". PETs concentrate on individual cases, directly relate to experience or sense-making, and reflect analytic concepts present across a transcript (Smith et al., 2022: 94). Once this five-step process was completed for each transcript, Group Experiential Themes (GETs) and subthemes were developed by comparing PETs across cases. This article explores the GETs:

- *There are these two separate parts of my brain: The contradictions between ADHD and autism*
- *Autism is a part of me, while ADHD is an add-on: Neurodiversity vs. medicalisation narratives*
- *Two sides of the same coin: ADHD and autism are the same or similar*
- *Shifting boundaries: neurodivergent vs neurotypical*
- *Striving for objective understanding*

- *A dynamic understanding of AuDHD.*

As an AuDHD researcher, I recognise, as Attias (2020: 57) notes, that “the neurological lens of difference can’t be separated out from who I am.” My neurodivergence shapes my analysis, aligning with feminist standpoint epistemology, which asserts that marginalised perspectives generate unique, situated knowledge (Collins, 1986). I apply an AuDHD frame of analysis which critiques neuroconventional systems and norms, contributing to the ‘neuro-diversification of sociology’ (Schneid and Raz, 2020: 2).

### Ethical Considerations

Ethical approval was obtained from Birmingham City University, with participants providing written informed consent and pseudonyms are used for anonymity. Resources on women, ADHD, and autism were shared post-study, with relationship building guided by a feminist ethic of care. I shared information about my role, motivation for the research, and personal interests. I remained open-minded and focused on participant viewpoints, whether they resonated with mine or not.

Member-checking occurred within email interviews. Reflexive journalling and discussions with a nonparticipating colleague validated interpretations and enhanced transparency (Lincoln & Guba, 1985; Denzin & Lincoln, 2005). Participant quotations are used to illustrate and support subthemes, bolstering the findings’ authenticity (Lincoln & Guba, 1985; Smith et al., 2022). Findings have been disseminated via public events and academic conferences and resonated with AuDHD women.

As an 'insider researcher,' a white AuDHD woman, the emotional toll was managed through reflexive journalling and deliberately slow scholarship (Berg and Seeber, 2016), which resists the neoliberal capitalist logic to work quicker and produce more. Instead, I embraced ‘crip time’ (Kafer, 2013) which bends the clock to meet disabled bodies and minds rather than bending our bodyminds to fit normative timescales and pressures. This involved allowing my natural rhythms of hyperfocus and productivity followed by rest and percolation time (see Craddock, forthcoming, for an in-depth exploration of this approach).

### A note on language use

Language preference is individual and evolving. Currently, I use ‘autistic and ADHD woman’ and ‘AuDHD’. Although grammatically incorrect, this reflects community preferences for identity-first language that integrates both conditions (Kenny et al., 2016).

## RECONSTRUCTED PARTICIPANT NARRATIVES

### Juliette

At 38, Juliette returned to live in England with her mother and cats after experiencing several turbulent years abroad. Currently unemployed, Juliette has a PhD in the social sciences and experience in professional roles globally. She enjoys solo travel, animals, nature, solitude, abstract art, electronic music, and cake.

Growing up in Southern England in a middle-class family, Juliette was a sensitive and creative child. Her father - who passed away during her childhood - was from Northern England and her mother is from Europe. Juliette has a younger brother who she suspects is autistic. Anxiety and depression began affecting her around the age of nine, exacerbated by her father's illness and bullying at school.

At 16, Juliette sought professional help for anxiety and body dysmorphia but found the support inadequate. A mental breakdown at 19 led to a misdiagnosis of bipolar disorder and hospitalisation. She was on mood stabilisers until her mid-twenties.

The following decade was marked by stress and fatigue, particularly when working in open-plan offices. In 2020, a period of introspection following severe anxiety prompted Juliette to take several online tests, including an ASD screening, which to her surprise returned high scores. This discovery led her to research late-diagnosed autistic women on YouTube, with whom she resonated. A clinical psychologist confirmed her combined ASD and ADHD diagnosis.

### April

April, 46, lives in Northern England with her teenage son and daughter. Since 2022, April has been self-employed after many years working as an NHS clinical psychologist. A pivotal moment came while supporting healthcare staff whereby she recognised her tendency to prioritise others over her own wellbeing. This realisation led her to shift from therapy, which was draining, to assessment-only work which she finds more manageable.

Working independently has greatly improved April’s life and well-being. She now goes to the gym regularly and is successfully losing weight.

April’s diagnoses of ADHD in late 2022 and autism in early 2023 provided insight into her experiences and brought significant positive changes to her life.

### Margaret

Artist Margaret, 50, teaches a vocational subject and fosters cats. She perceives herself positively as an unusual person with a few close friends but struggles in groups. Following a difficult breakup and emotional struggles, she began working on healing through therapy and self-compassion.

In 2022, she was diagnosed with ADHD and autism, having suspected she was ADHD following her niece’s diagnosis, with whom she shared many traits. Six months before her diagnosis, Margaret learned about the female presentation of autism and felt an immediate sense of understanding and comfort. It explained many of her quirks and answered long-standing questions. She faced resistance and inadequate support from the NHS, leading her to pursue a private combined ADHD and autism assessment.

The diagnosis was a relief, helping her to understand her executive function challenges and practice self-care. She is currently trying a non-stimulant medication to manage her symptoms.

Having grown up with emotionally unavailable parents, she has masked heavily throughout her life and maintains a difficult relationship with a mother who is unsupportive of her diagnosis. She is currently undergoing counselling during a period of positive change, which she is actively implementing.

### Chloe

Chloe, 34, lives in Southern England with their long-term partner and cat. Their partner is dyslexic and likely AuDHD, as are several family members. They have a small, tight-knit group of close friends, many of whom are neurodivergent.

Identifying as a bisexual, genderqueer Assigned Female At Birth (AFAB) person, they are exploring their gender identity. Embracing their geeky identity, their hobbies include gardening, medieval re-enactment, Irish dancing, and online fandoms.

Chloe has a PhD in the sciences and works in a related career. Being academically gifted in childhood, they remained undiagnosed for autism and ADHD until the pandemic. Growing up as a girl in the '90s and early '00s, this late diagnosis is frustrating but not surprising for Chloe.

Their history includes mental health struggles. In 2019, they began talk therapy for PTSD which triggered their self-identification as autistic, confirmed by an NHS assessment in early 2022. This diagnosis clarified many aspects of their life, but the remaining gaps prompted their exploration of ADHD. Consequently, in 2022, they obtained a private diagnosis and are currently exploring medication.

Chloe self-describes as a staunchly left-wing intersectional feminist and social justice advocate. They have deeply felt British working-class roots.

### Amelia

Amelia is a middle-aged woman who describes feeling different or an outsider from an early age. As a sensitive, thoughtful child, she often experienced periods of struggle and physical illness lacking clear cause. Anxiety plagued her childhood, and in her teens, she used alcohol to help her socialise and feel “normal”, but occasioned unsafe situations. Life was a rollercoaster, reaching crisis a decade ago following her grandson’s birth and her peri-menopause journey.

Her daughter suffered severe postnatal depression, prompting Amelia to leave work to support her. When her daughter left home, her 8-month-old grandson remained with Amelia, and she noticed his difficulty socialising and noise and touch sensitivities. After being dismissed by others, she began extensive research and obtained a private autism diagnosis for her grandson.

Her research of autism and ADHD deepened as she identified similarities between her grandson's struggles and her childhood. She also suspected her daughter had ADHD, which was later confirmed. Subsequently, she wondered if she may also be autistic, feeling "at home" in Facebook groups for women with autism before eventually pursuing a private assessment, doubting her GP would take her seriously.

The diagnosis confirmed she was autistic but also revealed she had ADHD. Processing this was challenging but brought clarity and answers, transforming her self-perception and dispelling years of feeling a failure.

### Meredith

Meredith, 45, is married with two children under the age of 10. Working in the public sector, she enjoys being in nature and listening to audiobooks in her leisure time. She experienced the significant loss of her mother to cancer while pregnant with her first child and now helps to care for her elderly father.

Her journey to diagnosis began following her eldest son's referral for an autism assessment. Observing many similarities between herself and her son, Meredith was exploring neurodivergence before a friend with neurodivergent support experience confirmed her suspicions. While waiting for an autism assessment, Meredith's neurodivergent therapist suggested she also consider ADHD, which she agreed with after reviewing the criteria and completing a screening questionnaire.

Having waited over two years for an NHS assessment, Meredith sought a private diagnosis. In 2023, both Meredith and her son received their diagnoses, embarking together on their journeys.

## FINDINGS

This section explores how late-diagnosed women navigate the experience of inhabiting the residual category of AuDHD. Women's narratives reveal an underlying ambivalence, reflecting tensions between medical and neurodiversity frameworks. Participants' experiences are dynamic, shaped by internal contradictions and societal narratives. It is argued that AuDHD's residuality impacts participants' identity formation and sense-making practices.

### *Ambivalence in identity formation: There are these two separate parts of my brain*

Participants consistently described a fragmented sense of self, pivoting between the characteristics of two conditions that are often contradictory. Juliette describes how this manifests in day-to-day struggles creating frustration:

> *My autism creates a need for order, formality, structure, routines, repetition, solitude, and intense interests, all of which are disrupted by my ADHD's chaotic impulse towards newness, variety, inconsistency, and inattention. So I am forever starting routines and habits (autism) but I can never stick to them because I lose motivation and get bored (ADHD).*

Participants differentiate between ADHD and autism by attributing traits to each condition to impose order and reconcile the torque arising from AuDHD's residuality. This tension reflects the previous clinical position that ADHD and autism were mutually exclusive.

Participants portray their identities as divided between their autistic and ADHD selves:

> *I find it difficult to articulate my AuDHD experience and identity in a holistic way. It very much feels as if there are these two separate parts of my brain – the autistic part and the ADHD part.* (Juliette)

> *Having autism and ADHD is hard to describe because although some traits are very similar, others are conflicting. I think for me it almost feels at times like I am two people.* (Amelia)

Juliette and Amelia both demonstrate the residuality of AuDHD and the complexities of occupying and making sense of it. Their accounts highlight the fractured sense of self created by living with both conditions, indicative of the struggle to form a unified identity while managing the contradictions between diagnoses.

### *The complementarity and fluidity of ADHD and Autism: Two sides of the same coin*

Despite viewing ADHD and autism as contradictory, participants also described how the conditions complemented each other, reflecting the fluidity of their experiences:

> *So I feel my autism alone would make me avoid these situations, but my ADHD drives me to do these things and enjoy them. (April)*

> *There may be much more going on beneath the surface in terms of the ADHD balancing out my autism, potentially providing me with greater flexibility, confidence, and sensory relief.* (Juliette)

> *It is a good thing at times because I feel they can balance each other out, but when they are conflicting, or one dominates the other it is a nightmare to navigate your life.* (Amelia)

These accounts suggest that ADHD and autism can simultaneously coexist to enhance participants' adaptability and resilience. Depending on the context, participants' experiences shift between balance and conflict, as Amelia and Juliette continue:

> *The traits overlap at times, cancel each other out, and at different periods in your life you may present as more autistic, or the ADHD may take the lead.* (Amelia)

> *I don't always feel as if my autistic and ADHD traits are in conflict; sometimes it's like they are working in tandem or like just one condition is dominant.* (Juliette)

Phrases such as “sometimes” and “at times” demonstrate the dynamic nature of the conditions. Their narratives reify autism and ADHD as externally existing forces outside of their control. This distances the conditions from the self; they are separate entities that minimise participants' sense of agency and occupy the driving seat of the individual, with the self becoming a passenger.

While the two conditions were perceived to positively interact at times, this "cancelling out" effect also complicated participants' path to diagnosis and produced further anxieties:

> *I have struggled a great deal with imposter syndrome; thinking that I am not autistic/ADHD enough to warrant the diagnoses. (Juliette)*

Juliette demonstrates another negative impact of occupying a residual category; the experience of falling between categories and not fully belonging in either. This resulted in "imposter syndrome", feeling that one does not deserve a particular claim or position, because they are illegitimate. April also expressed concerns about being perceived as a "fraud" and referred to "imposter syndrome". Such anxieties seemed to be heightened by the fluctuating and invisible nature of neurodivergence which makes it harder to "prove" or for others to "see". If "seeing is believing", the invisibility of AuDHD can lead to others questioning their validity.

Fear of being disbelieved by others, and further invalidated, underlies Amelia's reluctance to disclose her diagnoses:

> *I don't tell many people at all, I don't have many friends anyway, I'd like to be more vocal about it but do still feel no one would believe me.*

This fear of disbelief is perhaps especially profound for women who have been dismissed most of their lives in relation to their struggles, and who live within a patriarchal society that tends not to believe women (Banet-Weiser and Higgins, 2023). This gendered dimension was emphasised by April who worried that public perceptions of autism, shaped by a restricted male stereotype, could lead to her diagnosis being discredited because she does not conform to this narrow framing.

> *I worry others will prejudge based on it and also then assign any way they find you to 'because they're autistic'. People generally only know stereotypes, predominantly male traits.*

April reveals a concern about how others' limited understanding of autism might lead to her behaviour being narrowly interpreted through a distorted and reductive lens. This skewed perception risks others reducing her identity to a negative caricature.

Margaret reinforces April's apprehension about disclosing her autism diagnosis both because of its stigma and the risk that the legitimacy of her diagnosis would be questioned:

> *Initially I kept the Autism diagnosis much quieter than the ADHD diagnosis […] I felt that it was judged more harshly, or people would believe me less.*

Interestingly, both Margaret and April felt that their autism diagnosis was more stigmatised and contentious than their ADHD diagnosis. Other participants recalled negative experiences of disclosing their autism diagnosis to family members and work colleagues. Given the intersubjective nature of identity construction, it might be assumed that individuals would therefore have more negative feelings about their autism diagnosis than ADHD, reflecting others' responses. Yet, as will be shown in the following section, participants more readily embraced autism as part of their identity and identified strengths related to it, whereas ADHD was perceived as a negative foil to autism. This perhaps reflects the enduring influence of neurodiversity framings, although this influence does not seem to have extended more widely into popular culture and the sense-making frames of reference held by those in their lives.

### *Tension between the neurodiversity and medical models: Autism is a part of me, ADHD is an add-on*

A recurrent theme in participants' narratives was the tension between regarding autism as intrinsic to their identity - consistent with the neurodiversity model - and ADHD as a disruptive add-on - echoing the medical model:

> *They kind of oppose one another. The ADHD gets in the way.* (Margaret)
>
> *[What I like about ADHD] Nothing. It feels like this chaotic, disruptive, destabilising force within me.* (Juliette)
>
> *Fundamentally I think autism for me is my "core" diagnosis. I am autistic, it's part and parcel of the person I am and my personality.* (April)

These distinctions reflect how both neurodiversity and medicalisation narratives influence participants' understandings of their conditions. This dual perspective creates ambivalence over how participants relate to their diagnoses and highlights the inadequacies of rigid diagnostic categories. Juliette questions the validity or usefulness of this framing, and its failure to grasp "reality":

> *It feels as if autism is the core component of my neurotype, whereas the ADHD feels secondary and more mutable. I'm not sure that this type of thinking is particularly helpful or grounded in any sort of objective reality.*

Conversely, she concedes the medical model provides a heuristic explanation for others and *"some reassurance that I'm not just making it all up, that there are tangible neurological mechanisms underlying my experiences".* This concern with objective truth is threaded throughout participants' narratives and will be discussed later. It is understandable given participants' fears of others discrediting their diagnoses and the status of autism and ADHD as "hidden disabilities" that require disclosure and explanation. Nevertheless, Juliette's reflection suggests that while the medical model may offer reassurance and clarity, it ultimately fails to capture the full complexity of her experience.

### *Attempts to resolve ambivalence: Neurodivergent vs neurotypical*

Some participants distinguish between neurodivergent and neurotypical to settle this ambivalence. April says:

> *...both [ADHD and autism] mean you are neurodiverse, so 'different', yes, different to a neurotypical person.*

Here, "neurodivergent" provides a way to side-step the contradictions between ADHD and autism, resolving the torque emerging from AuDHD's residuality.

Chloe combines ADHD, autism, and other conditions under the neurodivergent umbrella, providing a shared identity distinct from the neurotypical majority:

> *The [live-action role play], [table-top role-playing games], and wider historical re-enactment communities all have a significant amount of overlap and absolutely attract a "certain kind of person" (geek/nerd/weirdo), and I now realise that that particular flavour of weirdness is just autism/ADHD/other neurodivergence, in any and all possible combinations.*

Chloe subverts weirdness into a positive signal of neurodiversity. This echoes 'queer flagging', choices made - usually over clothing – signalling a person's identity to other LGBTQ+ individuals in intra-community solidarity (Medhurst, 2023). Chloe's history in LGBTQ+ spaces is perhaps an influence here.

Similarly, Margaret associates neurodivergence with magic, clearly separating neurotypical and neurodivergent:

> *I was so relieved by my diagnosis. As my friend put it, "what if they say that I am a muggle? I don't know how to muggle".*

"Muggle" is a term from J.K. Rowling's Harry Potter books describing a person lacking magical abilities, and ignorant of the wizarding world. Both Margaret and Chloe have neurodivergent friends and family, enabling their conceptualisations of neurodiversity as a community. Margaret equates not receiving a diagnosis to being told she is 'normal' and outside the neurodivergent realm. Consequently, diagnosis becomes a gateway with clinicians serving as gatekeepers.

Like Margaret, Chloe required the validation of a medical diagnosis:

> *I desperately needed the external or "official" validation that I was actually autistic, and not just making it up or claiming something that didn't actually belong to me.*

Chloe reveals fears about fabricating or misappropriating an identity not belonging to her. Similarly, April states:

> *I said I knew, knew deep down but I 100% needed the external validation as I always have done and my biggest fear was I would be told I am not. I had also had a huge fear that afterwards I would wrestle with the idea I had still just made it up and convinced them but thankfully I haven't done this.*

Interestingly, April's professional experience as a clinical psychologist did not help her recognise her neurodivergence. Despite the positive impact of being diagnosed, her overall narrative reveals ambivalence over its validity. Dividing between neurotypical and neurodivergent is insufficient for resolving the ambivalence produced by inhabiting a residual category; However, belonging to a neurodivergent community may protect against its negative impact.

### *Attempts to resolve ambivalence: Striving for objective understanding*

Participants strongly desired clarity and certainty, seeking objective validation through medical diagnoses. However, this often conflicted with their ambivalence towards the limitations of diagnostic frameworks demonstrating AuDHD's residuality.

Margaret describes wanting to attend her friends' ADHD assessment to "see the diagnosis process from a removed viewpoint". Similarly, Meredith wishes to observe herself over CCTV in a café to see how loud noises impact her focus. She desires evidence from an external witness to objectively assess, reflecting diagnostic processes. This need for answers is especially important for autistic individuals who struggle with uncertainty.

To achieve clarity, some participants assume an observer role, attempting to recognise and record signs of autism or ADHD through a detached diagnostic lens:

> *Recently, I seem to often make a conscious mental note in certain situations of "aha, my autism is really making this difficult/really showing itself here". (April)*

April demonstrates how she attempts to apply this new understanding to herself, validating the diagnoses in the process. While this could relate to her professional experience as a clinical psychologist, other participants engaged in similar rationalisations, potentially attempting to reconcile diagnostic narratives with their lived experiences and understanding of themselves. However, this can sometimes result in challenging the validity of diagnostic categories and processes, as April queried:

> *Is ADHD even a separate thing or a manifestation of autism? Is the ADHD purely a trauma response?*

April exhibits participants' ambivalence towards medical and neuroscientific explanations for their conditions; seeking reassurance from objective models providing clear explanations for their experiences, while questioning the oversimplifications inherent in these frameworks and the confines of separating ADHD and autism into distinct categories.

### *A dynamic understanding of AuDHD*

Margaret and Meredith suggest that understanding evolves, highlighting the dynamic nature of inhabiting and understanding a residual category.

> *I did think they were separate conditions before I knew that I had them but now I see that they are tightly intertwined; although perhaps separate once, they probably are not anymore. They have shaped me. I thought my quirks were me, but they are me influenced by neurodiversity. I am proud of them*. (Margaret)
>
> *I'm still so early into this journey that I do still think of them as separate.* (Meredith)

Participants continually renegotiated their neurodivergent identity and understanding, demonstrating their unstable and unfixed nature. Inhabiting a residual category generates uncertainty, ambivalence, and a fluctuating comprehension of their lived experiences as they grapple with different explanations.

> *So I suppose that I am still experimenting with how I refer to my neurotype and new identity.* (Juliette)
>
> *Yes, my thoughts on both have changed over time, the more that I have learnt about them both and the more that I have learnt about myself.* (Margaret)
>
> *Apologies, this time it's not just been memory but really trying to think this through, as I feel my mind is often changing at the moment! (April)*

It may be assumed that a linear, temporal process occurs post-diagnosis, with those who had longer to process their diagnoses being likelier to incorporate a unified understanding of their conditions and identity, as Margaret implies. However, this is not evidenced in participants' narratives, for example, Juliette who had been diagnosed a couple of years earlier. Occupying a residual category creates fluid understandings lacking a linear route, continually negotiated and underpinned by ambivalence. This reflects broader tensions between the desire for certainty and the realities of diagnostic complexity, revealing how AuDHD overlaps and falls between two distinct diagnostic categories, generating torque between classifications and lived experiences.

## DISCUSSION

Before 2013, the DSM prohibited the diagnosis of comorbid ADHD and autism because of their inherent contradictions. Consequently, autism and ADHD (AuDHD) combined became a residual category, embodying two or more categories within a schema of "more than one of the above, where only one choice is allowed" (Star and Bowker, 2007). Classification systems struggle under the weight of conditions that resist simple definitions (Star and Bowker, 2007). Despite removing the restriction in the DSM-5, AuDHD continues to occupy this residual space, straddling and falling between two distinct categories.

There are several consequences of occupying this residual category, including ambivalence during identity formation; the tension between neurodiversity and medical frameworks; the desire for objective truth; and a dynamic understanding of AuDHD. Participants struggled to articulate cohesive identities incorporating both autism and ADHD, instead describing the two as separate, opposing parts of their brain, with each condition conceptualised as an internally autonomous agent. This reflects Tekin's (2011) critique of the Biomedical Disease Model which rationalises autism and ADHD as somatic illnesses, displacing agency and responsibility from an individual onto the "disease" itself. Tekin's argument helps explain why participants view their conditions as "others inside" or forces with the agency to act upon the self.

Participants' narratives support Weinberg's (2005) concept of addiction and insanities as "others inside," whereby conditions are described as non-human agents interacting with but separate from the self. This removes responsibility from the individual, abstracting addiction and insanities as distinct from a person's moral failings. Resembling Weinberg's "others inside", autism and ADHD become entities participants must contend with rather than integral aspects of their identities.

Weinberg (2005) emphasises how this framework of understanding developed within the socio-historical and political context of the USA. Similarly, I argue that participants' narratives – and particularly their underlying ambivalence - should be understood within the context of broader societal narratives rationalising autism and ADHD, and the tensions between the neurodiversity and medical models. Participants described autism and ADHD as distinct, medicalised conditions as categorised and diagnosed by the DSM, reinforcing the Biomedical Disease Model (Tekin, 2011). Conversely, participants viewed autism as core to their identity, with ADHD presented as a disruptive addition. This division reflects the influence of the neurodiversity movement, challenging the pathologisation of conditions like autism. Sinclair's (1993) foundational writing on neurodiversity conceptualises autism as an identity rather than a disorder, similar to how several participants comprehended the condition. In contrast, ADHD remains pathologised despite recent challenges to this medical deficits-based understanding, reflecting broader societal narratives framing ADHD as a disorder requiring treatment rather than an identity to be embraced (Bertilsdotter Rosqvist et al., 2023a).

Participants did not always frame ADHD negatively. Periodically, they described the two conditions as complementary rather than contradictory, reflecting the dynamic nature of their lived experiences. This fluctuation between conflicting frameworks indicates the ongoing renegotiation of identity common to late-diagnosed individuals. Davidson and Henderson's (2010) work on identity formation in the autistic context highlights how late diagnosis prompts the reinterpretation of past experiences, generating a reconfigured sense of self. This process was observable within my participants, who constantly shifted between medicalised and neurodiversity frameworks to interpret their combined diagnoses. Hacking's (2004) concept of the "looping effect" is instructive for describing how diagnostic categories influenced individuals' perceptions of themselves, which then affects their behaviour and experience of the condition. However, this impact is not one-directional; diagnosed individuals can resist and change diagnostic definitions. Participants' shifting self-narratives reflect a feedback loop incorporating both diagnostic labels into their identity while interrogating the diagnoses, reshaping their understanding of AuDHD.

Gender further complicates identity formation (Craddock, 2024a). Gould (2017) highlights how gendered diagnostic biases mean women are often diagnosed with autism and ADHD in later life, creating unique challenges for integrating these conditions into their identities. These gender dynamics are especially relevant because participants' late diagnoses exacerbate the ambivalence created by occupying a residual category. While receiving a diagnosis offered participants the validation and relief documented in research about late-diagnosed autistic individuals (Lilley et al., 2021), it also introduced considerable uncertainty. Participants sought objective understandings of themselves, their conditions, and their lived experiences to resolve this ambivalence. This desire for objective proof is perhaps reflective of the invisible and fluctuating nature of neurodivergence, combined with fears of being disbelieved and labelled a "fraud" in a gendered context where public imaginaries of autism and ADHD are restricted by gendered stereotypes and women's accounts are less likely to be believed (Banet-Weiser and Higgins, 2023).

Diagnostic categories often fail to capture the complexity of participants' lived experiences, creating a sense of diagnostic fuzziness (Kokanovic et al., 2013). This gap between categorisation and lived experience causes the torque generating ambivalence within participants' narratives. While torque can be harmful, it can also expand practices and knowledge by eroding rigid classification systems (Star and Bowker, 2007). Participants' uncertainty may ultimately trigger more inclusive and flexible understandings of neurodiversity and diagnostic categories. The neurodiversity movement has developed phenomenological counter-knowledge to the medical profession, challenging the epistemic injustice of individuals lacking the knowledge to understand themselves, leaving their experiences defined by others (Fricker, 2007).

Autism advocacy within the neurodiversity movement has a lengthy history, and it remains unclear whether ADHD will follow a similar demedicalisation path. There are added complications presented by ADHD being treated by medication and the negative impact of symptoms on individuals contributing to its common presentation as a medical disorder. Nevertheless, research within ADHD studies is following the path originally laid out by autistic advocates, the neurodiversity movement, and Critical Autism Studies to re-story ADHD as attention differences rather than deficits (Bertilsdotter Rosqvist et al., 2023a; Basten, 2023). It is likely that within the neurodivergent community, such efforts will result in the reinterpretation of ADHD.

While participant narratives revealed the influence of the neurodiversity paradigm and the medical model, they also appear to suggest that the neurodiversity framing of autism has yet to significantly influence mainstream popular culture. Autism was perceived as more heavily stigmatised than ADHD, leading participants to be less inclined to disclose an autism diagnosis. Despite this stigma, participants expressed a more positive view of their autism diagnosis, seeing it as an integral part of their core identity. In contrast, ADHD was often framed as a negative counterpart to autism. It is possible, then, that participants' reluctance to disclose their autism diagnosis was not solely due to stigma but also served as a means of preserving the positive aspects of their diagnoses. Significantly, participants' narratives suggest that while identity is constructed intersubjectively, these broader neurodiversity and medical narratives have more of an influence on their sense-making attempts than the perceptions of others in their lives.

This article is grounded in Western perspectives about autism, ADHD, medicalisation, and neurodiversity. Alternatively, Japanese categorisations of "developmental disorders" - including ADHD and autism (Shinomiya, 2024) - present less ambivalence and contradictions between the two. Similarly, challenges to identity construction are perhaps more strongly felt in Western contexts which valorise the fixed, singular self, whereas non-Western frameworks more readily accept the multiplicity of the self(s). A cross-cultural comparison would be fruitful for exploring differently-situated knowledge to destabilise the centrality of Western approaches.

Haraway's (1988) situated knowledge concept can also help clarify participants' ambivalence and uncertainty, by advocating for an understanding of knowledge shaped by context and perspective. Participants' shifting narratives reflect their position between the conflicting worlds of neurodiversity and medicalisation, situating their understanding of their conditions within frameworks shaped by broader sociohistorical and political contexts, and reinforced by cultural and geographical comprehensions of autism and ADHD.

This evidence calls for holistic assessments of neurodiversity incorporating multiple conditions, with post-diagnostic support reflecting the complexities of navigating multiple diagnoses to foster positive self-identity and self-esteem. Developing neurodivergent communities embracing comorbid conditions could provide a supportive space for individuals to successfully navigate their post-diagnostic identities. Likewise, shared knowledge of AuDHD may build stronger foundations for individuals to understand their lived experience and identity, and lessen the influence of the diagnostic categories currently creating AuDHD's residuality.

## CONCLUSION

This article conceptualised a combined autism and ADHD diagnosis (AuDHD) as a residual category and explored the consequences of this, including the impact on late-diagnosed women's identity formation, sense-making practices, and lived experiences. Drawing on the first study to explore women's lived experiences of autism and ADHD, it makes a significant and original contribution to the emerging body of literature by neurodivergent scholars that explores multiple neurodivergences by applying a critical lens to destabilise hegemonic neurotypical structures and knowledge. By creating an AuDHD phenomenology that prioritises the lived experiences of autistic ADHD women, this research offers a novel methodological framework that integrates feminist and collaborative approaches. It highlights the value of neurodivergent perspectives in generating inclusive, situated knowledge, building on previous research creating an autistic phenomenology.

The findings illustrate the intricate interplay between ADHD and autism in late-diagnosed women, revealing the dynamic nature of their lived experiences and sense-making narratives. Email interviews captured the confusing process of renegotiating self-identities and navigating a combined adulthood diagnosis of ADHD and autism. I have argued that the ambivalence in women's narratives reflects AuDHD's residuality, and the resulting torque produced by the gap between categorisation systems and lived experience. By occupying a residual category straining the boundaries of current diagnostic systems, these women challenge the rigidity of those systems and highlight the need for more nuanced and integrated approaches recognising the overlapping and sometimes contradictory nature of autism and ADHD. This has implications for conceptualising and understanding autism and ADHD, future diagnostic practices, and post-diagnostic support.

## Limitations

While in-depth IPA provided detailed data and analysis illuminating individuals' lived experiences, it does require a small sample size. Future research should broaden these findings, not to achieve generalisability - as this is not the goal of qualitative research - but to better capture the variety of experiences among late-diagnosed AuDHD women. The lived experiences of women with a combined diagnosis reflect the broader challenge of comprehending multiple, intersecting conditions while honouring the complexity of individual experiences. Future studies should consider the intersections of race and class, factors proven to influence diagnoses but regrettably unaddressed in this research. Without detracting from research prioritising women's voices, it would also be valuable to compare women's experiences with men's to further understand gendered implications.

## Funding:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

## Data availability statement:

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

## Acknowledgements:

Thank you to participants, the women who helped to refine the interview guide and reviewers for their helpful and generous comments.

## REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Attias, M. (2020). Mind-meandering as AD(H)D methodology: An embodied, neuroqueer practice of art-making and resistance in dialogue with Kurt Cobain's and Lee Lozano's journals. *Research in Arts and Education, 2020*(4), 53–85. https://doi.org/10.54916/rae.119283

Ayling R and Mewse AJ (2009) Evaluating internet interviews with gay men. *Qualitative Health Research* 19(4): pp. 566–576.

Banet-Weiser, S and Higgins K.C. (2023) *Believability: Sexual Violence, Media, and The Politics of Doubt,* London: Polity Press.

Basten, L. (2023) The Codex is Always on Crip Time: ADHD(ness) and Reading. *Reception: Texts, Readers, Audiences, History.* 15, 89-96.

Bell AV, Fitzpatrick R and Scrimshaw SC (2024) The sociology of diagnosis: Critical distance. *Sociology of Health & Illness* 46(1): pp. 1-7.

Benford P and Standen PJ (2011) The use of email-facilitated interviewing with higher functioning autistic people participating in a grounded theory study. *International Journal of Social Research Methodology* 14(5): pp. 353–368.

Berg, M. and Seeber, B.K. (2016) The Slow Professor: Challenging the culture of speed in the academy, University of Toronto Press.

Bertilsdotter Rosqvist H, Hultman L, Osterborg Wiklund S, Nygren A, Storm P and Sandberg G (2023a) Intensity and Variable Attention: Counter Narrating ADHD, from ADHD Deficits to ADHD Difference. *British Journal of Social Work* 53: pp. 3647-3664.

Bertilsdotter Rosqvist, H. et al. (2023b) ‘Naming ourselves, becoming neurodivergent scholars’, *Disability & Society*, 40(1), pp. 128–147. https://doi.org/10.1080/09687599.2023.2271155

Bowker, J. and Star, S.L. (2000) *Sorting Things Out: Classification and its consequences,* Cambridge, MA: MIT Press.

Chadwick, Z., Edmondson, A. and McDonald, S. (2022) ‘Engaging with animal-assisted interventions (AAIs): exploring the experiences of young people with ASD/ADHD diagnoses’, *SUPPORT FOR LEARNING*, 37(1), pp. 44–61. Available at: https://doi.org/10.1111/1467-9604.12394.

Cilia Vincenti S, Galea M and Briffa V (2023) Issues Which Marginalize Females with ADHD - A Mixed Methods Systematic Review. *Humanities and Social Science Research* 6(2).

Collins, P. H. (1986) ‘Learning from the Outsider Within: The Sociological Significance of Black Feminist Thought’, *Social Problems*, 33(6), pp. S14–S32. https://doi.org/10.2307/800672

Conrad P (1975) Discovery of hyperkinesis – notes on medicalization of deviant-behavior. *Social Problems* 23(1): pp. 12–21.

Craddock, E. (2024a) Being a woman is 100% significant to my experiences of ADHD and autism: Exploring the gendered implications of an adulthood AuDHD diagnosis, *Qualitative Health Research DOI: 10.1177/10497323241253412*

Craddock, E. (2024b) Raising the voices of AuDHD women and girls: exploring the co-occurring conditions of autism and ADHD, *Disability & Society* https://doi.org/10.1080/09687599.2023.2299342

Craddock, E. (forthcoming) The magpie mind in a capitalist cage: Reimagining autism, ADHD, and academia via a feminist disability lens**,** *Routledge Handbook of Feminist Disability Studies*

Davidson J and Henderson VL (2010) "Coming out" on the spectrum: Autism, identity and disclosure. *Social & Cultural Geography* 11(2): pp. 155-170.

Denzin NK and Lincoln YS (eds.) (2005) *The Sage handbook of qualitative research*. (3rd ed.) London: Sage Publications Ltd.

Fox RC (2000) Medical uncertainty revisited. In: Albrecht GL, Fitzpatrick R and Scrimshaw SC (eds) *Handbook of Social Studies in Health and Medicine*. London: Sage, pp. 409–425.

Fricker M (2007) *Epistemic Injustice: Power and the ethics of knowing*. Oxford: Oxford University Press.

Gould J (2017) Towards understanding the under-recognition of girls and women on the autism spectrum. *Autism* 21(6): pp. 703-705.

Hacking I (2004) *Historical Ontology*. Cambridge, MA: Harvard University Press.

Haraway D (1988) Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies* 14(3): pp. 575-599.

Hedlund, Å. and Jordal, M. (2024) 'Feeling like an untapped resource. Experiences of working life among nurses with ADHD and/or autism: An interview study', *International Journal of Nursing Studies*, 158. Available at: https://doi.org/10.1016/j.ijnurstu.2024.104857.

Huijg, D.D. (2020) "Neuronormativity in theorising agency: An argument for a critical neurodiversity approach". In: H. Bertilsdotter-Rosqvist, N Chown & A Stenning (Eds), *Neurodiversity studies: A new critical paradigm* (pp.213-217). London: Routledge.

Hours C, Recasens C and Baleyte JM (2022) ASD and ADHD Comorbidity: What Are We Talking About? *Frontiers in Psychiatry* (13).

Howard K, Katsos N and Gibson J (2019) Using interpretative phenomenological analysis in autism research. *Autism: The International Journal of Research and Practice* 23(7): pp. 1871–1876.

Jutel A (2009) Sociology of diagnosis: A preliminary review. *Sociology of Health & Illness* 31(2): pp. 278–299.

Kafer, A. (2013) *Feminist, Queer, Crip.* Bloomington: Indiana University Press.

Kelly C, Sharma S, Jieman AT and Ramon S (2022) Sense-making narratives of autistic women diagnosed in adulthood: a systematic review of the qualitative research. *Disability & Society* 39(3): pp. 1–33.

Kenny L, Hattersley C, Molins B, Buckley C, Povey C and Pellicano E (2016) Which terms should be used to describe autism? Perspectives from the UK autism community. *Autism* 20(4): pp. 442–462.

Kokanovic R, Bendelow G and Philip B (2013) Depression: the ambivalence of diagnosis. *Sociology of Health & Illness* 35(3): pp. 377–390.

Lilley R, Lawson W, Hall G, Mahony J, Clapham H, Heyworth M, Arnold SR, Trollor JN, Yudell M and Pellicano E (2021) "A way to be me": Autobiographical reflections of autistic adults diagnosed in mid-to-late adulthood. *Autism* 26(6).

Lincoln YS and Guba EG (1985) *Naturalistic Inquiry.* London: Sage.

MacLeod A (2019) Interpretative Phenomenological Analysis (IPA) as a tool for participatory research within Critical Autism Studies: A systematic review. *Research in Autism Spectrum Disorders* 64: pp. 49–62.

Medhurst, E. (2023) Flags and fashion: Expressions of solidarity through lesbian clothing, *Journal of Lesbian Studies,* 28(1), pp.8-23.

Milton D (2020) *The Neurodiversity Reader: Exploring Concepts, Lived Experience and Implications for Practice*. Brighton: Pavilion Publishing and Media Ltd.

Murray, D., Lesser, M. and Lawson, W. (2005) 'Attention, monotropism and the diagnostic criteria for autism', *Autism: The International Journal of Research and Practice*, 9(2), pp. 139–156. Available at: https://doi.org/10.1177/1362361305051398

Murray, D., Milton, D., Green, J., & Bervoets, J. (2023). The human spectrum: A phenomenological enquiry within neurodiversity. *Psychopathology*, 56(3), 220-230.

National Institute for Health and Care Excellence (2018) Attention Deficit Hyperactivity Disorder: Diagnosis and management, available at: https://www.nice.org.uk/guidance/ng87 (accessed 25/03/25).

Rafalovich A (2005) Exploring clinician uncertainty in the diagnosis and treatment of attention deficit hyperactivity disorder. *Sociology of Health & Illness* 27(3): pp. 305–323.

Redshaw R and McCormack L (2022) “Being ADHD”: a Qualitative Study. *Advances in Neurodevelopmental Disorders* 6(1): pp. 20–28.

Schneid, I. and Raz, A.E. (2020) ‘The mask of autism: Social camouflaging and impression management as coping/normalization from the perspectives of autistic adults’, *Social Science & Medicine (1982)*, 248, p. 112826. Available at: https://doi.org/10.1016/j.socscimed.2020.112826.

Shinomiya S (2024) Mediating local needs and global medical categories: Japan’s “developmental disabilities/disorders” as a local administrative term. In: *20th Biennial ESHMS Conference 2024: Intersectionality and Inclusion in Health*, Antwerp, Belgium, 3-5 July 2024.

Sinclair J (1993) Don’t mourn for us. *Our Voice* 1(3).

Smith JA, Flower P and Larkin M (2022) *Interpretative Phenomenological Analysis: Theory, Method and Research*. (2nd ed.) London: Sage.

Star SL and Bowker GC (2007) Enacting silence: Residual categories as a challenge for ethics, information systems, and communication. *Ethics and Information Technology* 9(4): pp. 273-280.

Taylor J and Bruckman A (2024) Mitigating Epistemic Injustice: The Online Construction of a Bisexual Culture. *ACM Transactions on Computer-Human Interaction* 31(4): pp. 1-34.

Tekin S (2011) Self-concept through the diagnostic looking glass: Narratives and mental disorder. *Philosophical Psychology* 24(3): pp. 357–380.

Turowetz J (2023) Disorder or difference: How clinician-patient interaction and patient age. *Sociology of Health & Illness* 46(1): pp. 171-188.

Weinberg D (2005) *Of Others Inside: Insanity, Addiction and Belonging in America*. Philadelphia: Temple University Press.

Williams SJ and Calnan M (1996) The ‘limits’ of medicalization?: Modern medicine and the lay populace in “late” modernity. *Social Science and Medicine,* 42(12): pp. 1609–1620.

Zola IK (1972) Medicine as an institution of social control. *Sociological Review* (20)4: pp. 487- 504.