

Counsellors with attention-deficit/hyperactivity disorder: the impact of
differences

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Abstract

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition with a proposed biopsychosocial aetiology. It is characterized by issues with attention regulation, hyperactivity, and impulsivity. The research question this paper seeks to answer is: how can ADHD impact a counsellor with the condition? Despite the prevalence of ADHD in adults, there is limited research exploring the unique experiences and challenges that ADHD counsellors face. This paper draws on empirical research and theoretical frameworks to explore the impact of ADHD on a counsellor. It discusses existing studies on the nature of ADHD and aspects of it which may be relevant, such as executive dysfunction and sensory issues and then explores how these may impact counselling and how they can be accommodated. Additionally, it examines positive aspects of ADHD, such as hyperfocus and entrepreneurship, and discusses how these may be advantageous to counsellors. This paper argues that understanding and addressing the unique challenges and barriers faced by ADHD counsellors is essential for promoting inclusivity and diversity in the counselling profession and, ultimately, providing better support for clients. This paper concludes that while ADHD entails significant obstacles to functioning in many areas of life, including counselling, it is also associated with some unique and relevant strengths. Those with ADHD can achieve their personal and professional goals if they have appropriate support and the right circumstances.

Counsellors with attention-deficit/hyperactivity disorder: the impact of differences

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition affecting an estimated 5% of children and 2.5% of adults globally (Song et al., 2021). It is characterized by inattention, hyperactivity-impulsivity, or a combination of both (American Psychiatric Association [APA], 2022).

ADHD is associated with significantly increased risk of many adverse outcomes, including premature death, road traffic accidents, divorce and imprisonment (Faraone et al., 2015). It is underdiagnosed in Ireland, and assessment and treatment are generally unavailable, regardless of financial status (Adamis et al., 2022; Bermingham, 2021; French et al., 2020). This potentially leaves a large number of people without the support they need to thrive. This challenging context underscores the need for increased understanding of how ADHD impacts people's lives, including those in the counselling profession.

The social model of disability and the neurodiversity paradigm offer frameworks suggesting new directions for ADHD research. The former posits that degree of disability is dependent on context: that disability is created by barriers in society which harm disabled people (Oliver, 2013). Our world is structured to be tolerable to neurotypical people; those with less common neurotypes must attempt to adapt to an environment not adapted to them, often feeling forced to hide their differences in the face of stigma (Bisset et al., 2021; Chapman & Botha, 2022; Norbury & Sparks, 2013). Judy Singer (1998) coined the term “neurodiversity” to reconceptualize conditions such as Autism, ADHD and dyslexia as part of the normal and essential variation between individuals, rather than as disorders. Proponents of neurodiversity argue that although these conditions are disabilities and confer disadvantages in some situations, they are

also associated with many neutral and even useful traits (Dwyer, 2022).

Neurodiversity means ADHD and other neurodevelopmental conditions enrich and benefit humanity, just as biodiversity benefits every organism in an ecosystem. Every type of person is part of human neurodiversity and has their niche. Thus, rather than focusing on deficits, the frameworks of the social model of disability and neurodiversity allow for a more comprehensive understanding of ADHD.

Promoting inclusivity in the counselling profession is a priority outlined in the latest strategic plan of the Irish Association for Counselling and Psychotherapy (IACP, 2021). This paper aims to contribute to this goal by attempting to answer the question of how ADHD may impact a counselor with this condition in the hopes this may facilitate their inclusion in the profession. This will be done using existing literature to explore the nature of ADHD, the difficulties it involves and how they can be accommodated, as well as whether it may have a positive impact in specific circumstances. While there is growing research literature on adult ADHD and substantial research on ADHD itself, there are scarce publications regarding its possible relevance to mental health professionals with the condition.

Chapter one describes some key differences those with ADHD have from a biopsychosocial perspective. It briefly outlines some of the genetic and nervous system differences found in ADHD before exploring the differences in brain function and social development as well as some environmental factors. The second chapter will investigate how much of what was previously discussed may negatively impact a counsellor in their profession, while considering how to accommodate these differences. Finally, in chapter three I will conclude with the possible social and psychological advantages to ADHD for counsellors.

Chapter One: What is ADHD?

ADHD is a neurodevelopmental condition, related to other neurodevelopmental conditions such as autism and specific learning disorders (APA, 2022; Antshel & Russo, 2019; Kern et al., 2012; Moyses-Oliveira et al., 2020). While once thought to be a disorder of childhood, it is now known to usually continue into adulthood (Franke et al., 2018; Weiss et al., 1985). Twin, adoption and molecular genetic studies suggest that this neurological condition is highly heritable, though environmental protective factors or stressors can impact its development and presentation (Hawi et al., 2015; Schuch et al., 2015; Sciberras et al., 2017). This chapter will describe different traits associated with ADHD, along with biopsychosocial factors that influence its presentation.

A core aspect of ADHD is deficits in areas of executive functioning (EF) (Willcutt et al., 2005). The American Psychological Association describes EF as “higher level cognitive processes of planning, decision making, problem-solving, action sequencing, task assignment and organization, effortful and persistent goal pursuit, inhibition of competing impulses, flexibility in goal selection, and goal-conflict resolution” (n.d.). Some differences can be observed in the brains of ADHD people as compared with neurotypical people. The prefrontal cortex, a region associated with EF, is especially implicated, and this has been speculated to at least partially explain the difficulties that those with ADHD have with EF (Faraone et al., 2015).

Memory difficulties are common in ADHD (Faraone et al., 2015; Skodzik et al., 2016). The executive dysfunction of poor working memory (WM) is a significant difficulty for most people with ADHD, a difficulty shared with those with dyslexia and up to 15% of children in general (Alderson et al., 2013; Fried et al., 2016; Roitsch & Watson, 2019). WM is necessary to be able to remember and work with a list of items, persist in a task, follow directions, stay on topic in a conversation, return to what one was doing after being interrupted, process

information and more (Baddeley, 1992; Tantam, 2013). WM deficits in ADHD generally persist with age, although there is some individual variation (Alderson et al., 2013; Karalunas et al., 2017). As a result, many with ADHD struggle academically, despite it not being a learning disability (Daley & Birchwood, 2010). Poor WM is also associated with low self-esteem, which ADHD children are likely to have, regardless of any academic success (Alloway et al., 2009; Foley-Nicpon et al., 2012; Holmes et al., 2010). WM difficulties can be exacerbated by sleep disturbances common in ADHD, including insomnia, delayed sleep cycle, and sleep apnea (Bijlenga et al., 2019; van Andel et al., 2020; Wynchank et al., 2017; Youssef et al., 2011). WM difficulties and sleep disturbances contribute to emotional dysregulation, which in turn negatively impacts WM (Groves et al., 2020).

Emotional regulation is another executive function. It involves noticing and identifying emotions, then selecting and evaluating strategies for regulating them (Christiansen et al., 2019; Gross, 2015). Emotional dysregulation is associated with deficits in WM and is commonly observed among those with ADHD (Corbisiero et al., 2012; Groves et al., 2020; Retz et al., 2012). The severity of this difficulty can result in a misdiagnosis of mood disorders such as Bipolar Disorder or Borderline Personality Disorder, especially in ADHD women (Ditrich et al., 2021; Haavik et al., 2010). Research suggests emotional dysregulation is also partly responsible for some social impairments seen in ADHD (Bunford et al., 2014; Sacchetti & Lefler, 2014; Staikova et al., 2013).

Executive functioning difficulties also contribute to difficulties with certain aspects of empathy that many ADHD individuals have (Lasmono et al., 2021; Pineda-Alhucema et al., 2018; Tatar & Cansız, 2020). Difficulties with EF are associated with poorer emotional intelligence and people with ADHD tend to have lower emotional intelligence (Alavi et al., 2019; Kristensen et al., 2014;

Yapça Kaypaklı & Tamam, 2019). This refers to the ability to work with one's own emotions and those of others: to be able to accurately recognize and evaluate emotions, to regulate them, and be able to use them to inform decisions in line with one's goals (Salovey & Mayer, 1990). Individuals with ADHD also have higher levels of alexithymia. Alexithymia is related to interoception and refers to difficulty identifying and describing emotions and internal states, ranging from hunger to sadness to excitement (Brewer et al., 2016). Emotional awareness is one aspect of emotional intelligence and difficulty recognising one's own internal states has been found to be associated with difficulty intuiting the emotions of others, though it does not necessarily impair all forms of empathy (Bird et al., 2010; Brewer et al., 2016; Saito et al., 2016; Samur et al., 2013).

People with ADHD are more vulnerable to trauma, and sensory differences may contribute to this vulnerability. They are more likely to suffer both traumatic events and post-traumatic stress disorder (PTSD) after a traumatic event (Wendt et al., 2023). Children who are found to have ADHD are more likely to go on to experience an adverse childhood experience after their diagnosis than neurotypical children assessed on the same date (Lugo-Candelas et al., 2020). Research suggests sensory processing differences, common in ADHD, may play a role in this and interact with how trauma is experienced (Bijlenga et al., 2017; Ghanizadeh, 2011; Schulze et al., 2020). These issues of sensory modulation can involve sensory over-responsivity, in which sensations are longer, faster, or more intense than would typically be expected, or sensory under-responsivity, which is the opposite (Ghanizadeh, 2011; Lane & Reynolds, 2019). These have been linked with anxiety and emotional dysregulation in ADHD (Hong & Hong, 2016; Lane & Reynolds, 2019). Sensory sensitivity, negatively correlated with resilience, may increase vulnerability to PTSD following a traumatic event (Borges et al., 2017; Gulla & Golonka, 2021; Wendt et al., 2023). Alexithymia can

be caused by higher levels of trauma (Edel et al., 2010; Kiraz et al., 2020).

Alexithymia, in turn, may contribute to the higher levels of PTSD associated with ADHD: it has been suggested that alexithymia increases the risk of traumatization (Eichhorn et al., 2014; Orejuela-Dávila et al., 2017).

Some biological differences associated with ADHD have been identified and likely play a role in the differences outlined thus far. Those with ADHD appear to have differences in genes related to the brain's dopamine transporters (Faraone et al., 2015; Gowrishankar et al., 2014; Grimm et al., 2020). Dopamine is a hormone and neurotransmitter with many functions, many of which those with ADHD struggle with. Its functions include motivation, attention, sleep and some executive functions: selective attention, memory, cognition, mood, emotion and emotional control. There also appear to be genetic and epigenetic differences in genes related to oxytocin receptors (Kalyoncu et al., 2017; Kumsta et al., 2013; Park et al., 2010). Oxytocin is a neurotransmitter involved in stress regulation, bonding and attachment and is implicated in behaviours such as eye-contact (MacDonald & MacDonald, 2010; Quirin et al., 2011). These differences in the oxytocin receptors have therefore been speculated to impact social cognition and empathy, and some studies measured less empathy among those with ADHD (Cordier et al., 2010; Uekermann et al., 2010). Oxytocin receptor differences may also cause difficulties forming secure attachments (Chen et al., 2011; Tantam, 2013). As many as 93% of those with ADHD have an insecure attachment style (Storebø et al., 2013). Other biological factors that have been implicated in the development of ADHD include altered brain structure or function, and exposure to lead or other environmental toxins (Faraone et al., 2015).

These neurological, biological, and psychological differences manifest in practical difficulties as well as strengths and weaknesses typical of people with ADHD which will be discussed in the next sections.

Chapter Two: Counselling with ADHD: challenges and implications

We have seen that ADHD can be disabling in many ways, this section will explore how these difficulties might impact an ADHD counsellor's work, and what accommodations may mitigate these difficulties.

As mentioned previously, those with ADHD are likely to have insecure attachment styles. Avoidant attachment is the most common style among people with ADHD and as few as 7% have a secure attachment style (Koemans et al., 2012; Storebø et al., 2013). Secure attachment is the most common style among the neurotypical population, at approximately 70%, though with cultural and socio-economic variation (Keller, 2018; van IJzendoorn & Kroonenberg, 1988). Attachment style refers to the manner in which a person bonds in interpersonal relationships and the three insecure attachment styles, avoidant, preoccupied, and fearful, imply interpersonal difficulties (Bowlby, 1977; Dagan et al., 2021). Counsellor attachment appears to influence therapy outcomes, with secure attachment predicting a better therapeutic relationship and better outcomes (Carr & Egan, 2017; Degnan et al., 2014; Kietaihl, 2012; Slade & Holmes, 2019).

It does not follow that insecure attachment will prove to be an obstacle for the ADHD counsellor. Firstly, attachment styles are not fixed and can change over the lifetime (Sutton, 2018). In counselling or in a close relationship with someone who has a secure attachment style, previous attachment styles tend to shift towards secure attachment (Slade & Holmes, 2019; Sutton, 2018; Taylor et al., 2014). Therefore, an ADHD counsellor, having undergone personal counselling as part of their training, will likely have higher attachment security.

On the other hand, some research shows that an insecurely attached counsellor can be more helpful to some clients (Lu et al., 2022; Petrowski et al., 2021; Talia et al., 2019). Trained counsellors with ADHD are likely to also have improved self-awareness and knowledge to mitigate the possible negative impact of their attachment style (Kietaibl, 2012; Lennie, 2007). An awareness of emerging research on insecure attachment in counsellors will help them to capitalize on its positive aspects.

Eye-contact differences are another possible barrier to the therapeutic relationship, as eye-contact is commonly viewed as necessary for active listening (Ellison & Meyer, 2020). Individuals with ADHD often avoid making eye-contact, which can be disconcerting for many neurotypical clients (Frick et al., 2022; Mauriello et al., 2022; Muszkat et al., 2015; Niedźwiecka, 2020). In western cultures, eye-contact has been shown to facilitate conversational turn-taking and feelings of connection and is typically part of social skills training for ADHD (MacDonald & MacDonald, 2010; Willis et al., 2019; Wohltjen & Wheatley, 2021). Research on the causes of eye-contact differences in ADHD is scarce, however, eye-contact increases cognitive load and is uncomfortable for many neurodivergent people, suggesting it may be disadvantageous when working with these clients (Jellett & Flower, 2023; Niedźwiecka, 2020; Stuart et al., 2022; Trevisan et al., 2017). Furthermore, eye-contact was not part of active-listening when it was originally developed, and research suggests it is not a key aspect of it (Collins, 2022; Rogers & Farson, 1957).

Consciously learning to make eye-contact despite one's discomfort doing so is just one example of camouflaging, also known as masking (Chapman & Botha, 2022; Goffman, 1959). This refers to strategising to appear "normal" in order to avoid rejection by others. It is one result of the difficulties that those with ADHD have interacting with neurotypical peers. It can also involve

avoidance of social activities or seeking help, which are important activities for the maintenance of mental health (Cook et al., 2021; Kelly et al., 2022; Young et al., 2020). Many with ADHD learn to camouflage from an early age in an attempt to be accepted by neurotypical peers and adults (Nyström et al., 2020; Quinn & Madhoo, 2014). This is evidence of their ability to adapt, however, it may also bear a heavy cost: camouflaging is associated with internalizing symptoms, which in turn are associated with higher rates of suicide and non-suicidal self-injury (Hinshaw et al., 2012; Katzman et al., 2017). Though it is not possible to prove a direct causal relationship between these adverse outcomes and camouflaging, it does appear to be subjectively distressing (Kelly et al., 2022; Nyström et al., 2020; Sheerin & Mannion, 2021). People with ADHD can adapt and use appropriate eye-contact as well as many other social skills when they camouflage, however, as the majority of this is done consciously, it implies further increased cognitive load, which interferes with WM (Oberauer, 2019).

The WM deficits associated with ADHD may present a challenge in the counselling room in numerous ways. Research suggests listening and processing language is more mentally taxing for those with ADHD due to WM differences (Taitelbaum-Swead et al., 2019). Furthermore, clients often share considerable information in a short period, and counsellors may want to hold something in mind to return to it or inquire about it later. Strong WM would allow one to do so without interfering with their ability to listen, and so may not be possible for many with ADHD. However, WM is a “mental blackboard”, and substituting this with a paper notebook is an effective “external” WM strategy (Dirette & Anderson, 2016; Wickelgren, 1997). Counsellors can use a notepad to write down occasional keywords as reminders, compensating for this difficulty. Note-taking has potential to harm the therapeutic alliance, therefore the notepad’s purpose

should be explained to the client to mitigate this in the interests of transparency (Christie et al., 2015; Levitt et al., 2006).

WM is also thought to be involved in the process of discounting unnecessary information, including sensory information (Oberauer, 2019). The sensory issues discussed in chapter 1 have the potential to interfere with concentration and emotional regulation in the counselling room (Lane & Reynolds, 2019; Schulze et al., 2020). However, in private practice counsellors have a certain degree of control over their environment: they can schedule sessions to allow for sensory breaks and can make adjustments to the room to reduce cognitive load and allow for their sensory needs (Gutman & Szczepanski, 2005; Weber et al., 2022). Examples of this can include, replacing fluorescent lighting, replacing uncomfortable chairs, and modulating background noise (Gutman & Szczepanski, 2005).

WM is not only impacted by cognitive load and physical sensations, but also by emotions (Hou & Cai, 2022). When WM is overtaxed, it can interfere with an ADHD person's ability to use tools and techniques to emotionally regulate (Groves et al., 2020). This suggests that ADHD counsellors will need to be especially mindful in managing their emotions during and outside sessions. Emotional exhaustion is associated with burnout in counsellors and ADHD is associated with higher burnout levels in other fields (Brattberg, 2006; Yang & Hayes, 2020). One long-accepted method to prevent burnout is managing caseload to meet the individual counsellor's current capacity (Jackson et al., 1986). The ADHD counsellor may need to be especially cautious in this regard; the ability to decide one's workload is important, with a reduced workload being a common and appropriate accommodation in other areas of employment (Adamou, 2019).

The value of self-care is well-researched and widely known among counsellors (Posluns & Gall, 2019). For those with ADHD, this may be particularly important, and look somewhat different. ADHD is linked to a four-fold increase in attempted suicide and suicidal ideation is common (Bauer et al., 2017; Eddy et al., 2019; Fuller-Thomson et al., 2020). It is also associated with higher rates of co-occurring mental health difficulties such as depression and anxiety, and with lower self-esteem, self-compassion and resilience (Beaton et al., 2020; Choi et al., 2022; Harpin et al., 2013; Newark et al., 2012). Resilience refers to an individual's capacity to psychologically withstand traumatic events and both it and self-compassion are associated with less burnout (Aburn et al., 2016; Coaston, 2017; Masten et al., 1990). With lower rates of all these salutary features in the ADHD population, they are likely to be appropriate areas of focus for the self-care of the ADHD counsellor.

We have seen how self-awareness, ADHD awareness and self-care can enable an ADHD counsellor or their employer to make accommodations and enable them to be less negatively impacted by their condition. The following chapter investigates how ADHD may positively impact the counsellor.

Chapter Three: Could ADHD be an asset to counsellors?

As has been shown, ADHD implies many difficulties in a person's life, however, it can also confer advantages for the individuals and those around them. This chapter will explore how these may affect the suitability of ADHD counsellors for the profession, from the dual perspectives of counsellor and client.

From the perspective of the person with ADHD, counselling may be an ideal profession if they are interested in mental health and eager to help others. This passion may help them to "hyperfocus" on the ever-evolving literature and enter a "flow" state when working with clients. Hyperfocus refers to intense

immersion in an engaging activity, whereby the person becomes unaware of other stimuli and their performance of the task improves (Ashinoff & Abu-Akel, 2019; Ozel-Kizil et al., 2016; Sedgwick et al., 2018). It is a similar phenomenon to Csikszentmihalyi's "flow" (1988), a subjectively pleasant mental state of vigorous concentration. However, unlike flow, it is associated with workaholism and addiction (Hupfeld et al., 2018). Therefore, the counsellor must not lose sight of the importance of self-care and the carefully managed workload mentioned in the previous chapter (Posluns & Gall, 2019).

As well as interest, urgency can allow an ADHD brain to function optimally (Brown, 2017), and studies suggest that emotional salience improves memory in those with ADHD (Fabio & Capri, 2014; Krauel et al., 2007). Therefore, the highly important and emotive nature of counselling may be well-suited to ADHD counsellors, potentially reducing the impact of memory difficulties. Another fortuitous common ADHD trait is novelty-seeking (Gomez et al., 2017; Pinzone et al., 2019). With hundreds of therapy approaches and interventions, and the requirement for continuous professional development (IACP, n.d.), the ever-changing nature of the profession is likely to keep the ADHD counsellor engaged, particularly if working integratively.

Regarding practical demands of the profession, counsellors often need to be good entrepreneurs, as they usually work in private practice (IACP, 2022). This suits ADHD people, who are more likely to be entrepreneurs (Verheul et al., 2016). ADHD entrepreneurs often feel many aspects of ADHD are strengths which support them in their role (Antshel, 2018; Hatak et al., 2020). The autonomous nature of counselling is also compatible with an entrepreneur mindset: counsellors choose their specialization, work relatively independently, and have flexibility in choosing their hours, which is important given that the

majority with ADHD have a delayed sleep cycle (Bijlenga et al., 2019; van Andel et al., 2020).

Thus, it can be concluded that counselling can be an advantageous profession for someone with ADHD, but could having an ADHD counsellor benefit a client?

Compassion, closely correlated with post-traumatic growth, is an important aspect of counselling (Malhotra & Chebiyan, 2016). Jung (1966) introduced the metaphor of the wounded healer over half a century ago, and it has been integral to psychotherapy since. Drawing on Greek mythology, it proposes that the counsellor's experiencing of their own pain allows them to help others. This suggests mental health struggles, such as comorbidities associated with ADHD, would increase a counsellor's compassion for their client, and indeed people with higher numbers of ADHD difficulties report offering more support to those around them (Choi et al., 2022; Michielsen et al., 2013). In qualitative studies, both bloggers and therapists with ADHD felt their experiences made them more understanding of others' struggles (Elliott & Ragsdale, 2020; Fleischmann & Fleischmann, 2012). Some bloggers felt ADHD had left them with a drive to help others and to make their suffering meaningful by preventing similar in others (Fleischmann & Fleischmann, 2012).

A concept related to compassion is that of altruistic justice sensitivity. This refers to feeling substantial concern over injustice experienced by others (Schmitt et al., 1995). It is negatively correlated with prejudice and discrimination and higher levels of it have been measured in those with ADHD (Bondü, et al., 2021; Chapman & Botha, 2022; Schäfer & Kraneburg, 2012). This ability to empathize with the marginalized and/or victimized is a desirable trait in a counsellor. The IACP code of ethics prohibits discrimination and research suggests ADHD counsellors with enhanced altruistic justice sensitivity will

recognise and be motivated to end prejudice both in themselves and in the wider field of counselling (IACP, 2018; Schäfer & Kraneburg, 2012). This includes ableism which, as neurodivergent individuals, they may be subject to, whether internalized or from external sources (Chapman & Botha, 2022; Elliott & Ragsdale, 2020; Masuch et al., 2018; Ong et al., 2009; Smith et al., 2008).

Social skills are relevant to counselling, though it does not necessarily follow that poor social skills are an obstacle to forming a therapeutic relationship (Anderson et al., 2009). As mentioned, people with ADHD often struggle with social skills and being accepted by neurotypical peers through to adulthood (Bunford et al., 2014; Gutman & Szczepanski, 2005; McKee, 2014; Sacchetti & Lefler, 2014). Traditionally, interventions aimed at improving ADHD children's social relationships focused on modifying their behaviour. However, recent evidence suggests social skills training is less effective if it does not also help neurotypical peers understand individuals with ADHD, thus, interventions and research are shifting towards this approach (Mikami et al., 2017). This suggests that mutual understanding between individuals is necessary for skilled social interactions, which has clear implications for counselling.

Empathy is fundamental to effective counselling (Elliott et al., 2018; Rogers, 1957). The evidence suggesting that ADHD is linked with lower empathy has been disputed (Chapman & Botha, 2022; Ghrear et al., 2021). Interpretation of findings may have been impacted by what is known as the double empathy problem (Milton, 2012). This refers to mutual difficulties that people with different ways of experiencing the world have in understanding each other: when two people sufficiently different interact, both will have equal difficulty empathizing, and this difficulty is not a sign of impairment in the more unusual of the two. Thus, neurotypical researchers using neurotypical measures for empathy may obtain misleading results when studying ADHD subjects

interacting with neurotypical people. It is possible that the ADHD interaction style becomes advantageous when working with some client groups. Research on this topic is limited, but evidence from other categories of relationship, friendships and marriages, implies a mutual understanding. Individuals with ADHD tend to form friendships with others who have ADHD or ADHD traits (Blachman & Hinshaw, 2002; McKee, 2014; Normand et al., 2011). They are also significantly more likely to marry a spouse who is neurodivergent, and up to 7.5 times more likely to have a spouse who also has ADHD (Nordsletten et al., 2016).

We saw in chapter two that those with ADHD are capable of camouflaging and adapting to neurotypical social norms, but, when specializing in working with certain populations, they may not have to.

Camouflaging is not a new concept in counselling. Donald Winnicott (1965/2018, Chapter 12) described a “false self” created in an attempt to comply with others’ expectations, to protect from the annihilation that the infant implicitly feared as the inevitable result of isolation and abandonment. In contrast, the “true self” was necessary for a feeling of “aliveness” and “spontaneity” (Winnicott, 1965/2018, Chapter 12). Similarly, Carl Rogers (1961/1995) wrote that in the presence of conditions of worth, “congruence” could not emerge. This term referred to his conceptualization of authenticity, and he considered it necessary for personal development and growth (Rogers, 1957; Rogers, 1959/2013). Similar ideas are finding support in the emerging research into stigma and camouflaging in neurodivergent individuals: conditions of worth imposed by neurotypical expectations appear to have a detrimental impact on the neurodivergent person’s ability to live congruently, and many grow up thinking they are “impolite” “strange” or worse (Cook et al., 2021; Hansson Halleröd et al., 2015; Nguyen & Hinshaw, 2020).

Qualitative studies suggest those with ADHD camouflage less with fellow neurodivergent people (Frame et al., 2003; Munson et al., 2014; Priscott & Allen, 2021). Clients saying that they can “be themselves” with their counsellor predicts a strong therapeutic alliance (Kelley et al., 2010; Moore & Gelso, 2011). There is also some evidence that counsellor-client similarity improves therapy outcomes and therapeutic alliance and that some clients prefer counsellors similar to themselves (Anestis et al., 2020; Coleman, 2006; Taber et al., 2011). All this suggests that ADHD counsellors working with ADHD or otherwise neurodivergent clients may have less difficulty establishing a strong therapeutic relationship than their neurotypical peers, which is essential to therapy outcomes (Wampold, 2015). There is a severe lack of ADHD services in Ireland with significant waiting lists for those seeking support privately and effectively no support available for adults through the public system (French et al., 2020; Gavin & McNicholas, 2018; Tatlow-Golden et al., 2017). The ADHD counsellor may be particularly suited to this niche.

As mentioned, one result of camouflaging is becoming less likely to seek support from others, one trait predicting low emotional intelligence and resilience (Ong et al., 2009; Peña-Sarrionandia et al., 2019). We have seen that ADHD individuals are likely to have lower-than-average emotional intelligence, but this is unlikely to be true of ADHD counsellors. Studies suggest that counselling training improves emotional intelligence and resilience (Abdullah & Noah, 2005; Lim, 2019; Pearson & Weinberg, 2016; Roebuck & Reid, 2019). This will benefit not only the counsellor but also their client, as counsellors with higher emotional intelligence and resilience are less vulnerable to burnout (Gutierrez & Mullen, 2016) and higher counsellor emotional intelligence and the associated trait of resilience also appear to predict more positive outcomes for clients (Feinstein et al., 2015; Kaplowitz et al., 2011; Rieck & Callahan, 2013).

A resilient counsellor can withstand and be enriched by hardship in both personal and professional life (Bartoskova, 2015). Adversity and traumatic events do not guarantee adverse outcomes, they potentially lead to post-traumatic growth: positive psychological change resulting from crises (Tedeschi & Calhoun, 1996). This growth manifests in five areas: interpersonal relationships, spirituality, personal strength, possibilities in life, and appreciation of life (Peterson et al., 2008). The likelihood of traumatic experiences leading to post-traumatic growth is mediated by a person's resilience level (Bensimon, 2012). Although ADHD is associated with less resilience, it seems likely that a qualified ADHD counsellor is resilient (Harpin et al., 2013). Research has suggested that ADHD university students have higher resilience than even the general population (Wilmshurst et al., 2009). This is unsurprising: those with ADHD are unlikely to enrol in university and less likely to graduate from it, and studies indicate that those few who do owe their success in part to their resilience (Adaralegbe et al., 2022; Chen et al., 2022; Sedgwick, 2017). Emotional intelligence has been found to build resilience, therefore, it can be concluded that any ADHD counsellor will likely have high resilience, both as a result of being able to obtain a third-level qualification while having ADHD, as well as the increased emotional intelligence fostered in their counselling training (Armstrong et al., 2011; Delhom et al., 2020; Lim, 2019; Pearson & Weinberg, 2016).

Earnest Hemingway wrote that "The world breaks everyone and afterward many are strong at the broken places." (Hemingway, 1929, p.154). We have seen that ADHD itself, as well as many of the challenges associated with navigating it, can result in traits that enrich their work.

Conclusion

This paper has investigated the impact of ADHD on counsellors with the condition, a question important to the goal of promoting inclusivity in the counselling profession. To answer it, I explored the nature of ADHD, asked what accommodations may be necessary to remove barriers the ADHD counsellor may face, and how counsellors may be impaired or benefited by their ADHD.

This investigation of existing research has found many ways ADHD traits are relevant in counselling, including aspects of ADHD that underscore the importance of neurodiversity to this profession. ADHD, a neurodevelopmental condition and disability, involves differences in areas of executive function, emotion regulation and attention, sensory processing and interpersonal relationships. ADHD counsellors face some specific challenges and will benefit from emotional intelligence and resilience, as well as an understanding of how ADHD will impact them, the importance of self-care, and what accommodations to seek if necessary. They are also likely to benefit from the personal counselling, personal development, and resulting growth that is a core part of their training. I have identified some strengths of those with ADHD and that their inclusion in the counselling profession is likely beneficial for clients, perhaps neurodivergent clients in particular. Finally, I shared evidence that adversity can be salutary and can enhance compassion for others.

This paper was limited by the fact that it is based on existing literature and does not include original empirical research. A further limitation is that the research methodologies in existing literature are heterogenous and a detailed meta-analysis would have been difficult. In future research, a detailed systematic review on existing primary research may prove fruitful, as would primary research on the experience of neurodivergent clients working with ADHD counsellors. It would also be valuable to use qualitative studies to investigate the experiences of ADHD counsellors in their initial years of training and practice, its

impact on them and on client outcomes, and factors contributing to or impeding success.

This paper has shown that the counselling profession entails the flexibility, autonomy and vibrancy that suits ADHD mindsets. The evidence demonstrates some of the potential benefits of neurodiversity in the counselling profession and the importance of acknowledging diversity in the pursuit of effective and ethical practice. In keeping with neurodiversity and the social model of disability, the impairments associated with ADHD should be accommodated, not camouflaged or overcome, in order to harness the associated strengths.

I hope that by highlighting the relevant strengths and challenges associated with ADHD, this work may provide a valuable resource for counsellors, counselling trainers, and mental health professionals, and provide hope to aspiring ADHD counsellors. Counsellors with ADHD have beaten the odds, have atypical strengths, and bring a unique perspective to the field. With ADHD, many things are difficult and nothing is impossible.

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