

A Learning Specialist's Guide to ADHD

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ZAC CLARKE

CONESTOGA OPEN LEARNING
KITCHENER



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Contents

Preface	ix
Acknowledgements	x
Author Acknowledgements	xi
Attributions	xii
Accessibility Statement	xiii
About the Author	xiv
 Part I. <u>Introduction</u>	
 ADHD Goes to College	3
The Growth, Care, and Feeding of This Guide	5
 Part II. <u>ADHD Revisited</u>	
 ADHD and Its Discontents	9
What We Talk About When We Talk About ADHD	10
Finite “Presentations” – Infinite Variations	12
Getting a Diagnosis (As an Adult)	14
A Later in Life Diagnosis	17
Meeting with a Newly Diagnosed Student	18
 Part III. <u>Major Areas of Struggle and Compensatory Strategies</u>	
 The Kinds of Strategies People Use	23
 Part IV. <u>Strategies: Procrastination and Getting Things Done</u>	
 Procrastination	27
<i>“Why can’t I just get started?”</i>	
Breaking Assignments into Pieces (to the Extreme!)	28
Engineering the Environment	29
Social Obligations	30
Harnessing Interest to Spur Action	31
Environmental Cuing	32
Body Doubling	33

Part V. Strategies: Time Management and Organization

Time Management and Organization	37
<i>"I just keep it all in my head."</i>	
Keep Organizational Systems Simple	38
Making Time Tangible	39
Scheduling Based on Energy Level	41

Part VI. Strategies: Memory Issues

Memory Issues	45
<i>"Whoops. Sorry, I forgot."</i>	
Only Handle it Once (OHIO)	46
Writing Everything Down	47
Memory Support for Math	48
Memory on Tests	49

Part VII. Strategies: Focusing in Class

Focusing in Class	53
<i>"Um, can you repeat the question?"</i>	
Focusing in all Kinds of Classes	54
Exercise and Focus	56
Fidgets and Other Sensory Tools	57

Part VIII. Hidden Symptoms of ADHD

Hidden Symptoms: Further Complications	61
Specific Learning Disorders	62
Sleep Issues	65
Non Suicidal Self Injury	66
Rejection Sensitivity	67
Mind Wandering	68
Hyperfocus	69
Decision Paralysis	70
Overcommitting	71
Stalling Out on a Projects	72

Part IX. ADHD Medications

ADHD Medications: Generally Safe and Effective	75
Classes of ADHD Medications	76

Doin' Drugs at School	78
Self-Medication: Caffeine, Nicotine, and Other Substances	80
Part X. <u>Sex, Gender, and ADHD</u>	
Sex, Gender, and ADHD: It's Complicated	83
Licences with Language	84
The Invisible Women	85
Differences in Diagnostic Category	86
Brain Differences	87
Comorbidities and Gender	88
Part XI. <u>ADHD Strengths</u>	
ADHD Strengths: Juggling Double Edged Knives	91
The Superpower Narrative	92
ADHD and Creativity	93
Part XII. <u>ADHD Coaching</u>	
ADHD Coaching: Choose your own Adventure	97
Evidence of Efficacy	98
What's the Difference Between ADHD Coaches and Learning Specialists?	99
References	101

Preface

If you have noticed that much of the vast amount of information on adults with ADHD on the internet and social media is based on opinion rather than evidence, and you are craving something more substantial, get ready to fill your boots. This guide gathers the most useful and accurate research on adult ADHD and examines how it applies to helping students with ADHD succeed in higher education.

Written by a Learning Specialist with ADHD themselves, this guide is overflowing with practical strategies to support adult students with ADHD in addressing procrastination, organization, time management, focusing in class, note-taking, working memory, test preparation, and more. Since ADHD doesn't like to travel alone, we will also look at the relationship between ADHD and problems with rejection sensitivity, decision paralysis, and non-suicidal self-injury, sleep, specific learning disorders (reading, writing, and math), and more. And no guide on ADHD would be complete without discussions of the medical model vs the social model of disability, how ADHD manifests in adults differently than in children, the various ADHD medications and their side effects, how sex and gender do and don't affect ADHD, and ADHD "strengths" and the trap of labelling ADHD a superpower.

Not a "Learning Specialist?" No problem. There is something here to suit all tastes. Whether you are a student yourself, a parent, a teacher, a tutor, or someone with one of the grab-bag titles now preferred by institutions, such as "Student Success Advisor," "Study Skills Tutor," or "Executive Functioning Skills Development Consultant," this guide is for anyone interested in helping adult students with ADHD succeed.

Acknowledgements

Land Acknowledgment

At Conestoga College, we would like to acknowledge that in Kitchener, Waterloo, Cambridge, and Brantford, we are located on the Haldimand Tract, the land promised to the Haudenosaunee people of Six Nations, which includes six miles on either side of the Grand River. This is the traditional territory of the Anishinaabe, Haudenosaunee, and Neutral peoples. Recognizing the land is an expression of gratitude and appreciation to those whose environment we reside in and a way of honouring the Indigenous people living and working on the ground for thousands of years.

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Julie Mandal, MLIS, Executive Director, Library & Learning Services
Meg Bauman, MEd, Associate Director, Learning Services

Open Learning Team

Kimberlee Carter, MA, BEd, Associate Director, Libraries and Open Learning
Juliet Conlon, MLS, Scholarly Communications Librarian
Stephanie Yantha, Instructional Designer — OER
Rachel Stuckey, Instructional Designer — OER

Student OER Assistants

Girish Bhuteja
Adil Farid
Rio Kim
Keshav Markan

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— Zac Clarke

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About the Author

Zac Clarke has spent the last 15+ years of his career at various educational institutions, working to take the danger out of being different. A former Learning Specialist at Conestoga College, he is currently a Learning Strategist in the College's Community Integration Through Co-operative Education (CICE) program. Zac earned his B.A. and B.Ed at Trent University. He is also a qualified intermediate/senior teacher in both Ontario and Nova Scotia, and completed an Education Specialist (mild to moderate) credential in California.

PART I
INTRODUCTION

ADHD Goes to College

The number of students with ADHD in higher education has been increasing over the past two decades. In a 2022 survey of 16,000 first-year college/university students across 9 countries, 15.9% identified as having ADHD (Mak et al., 2022). Given that in Canada, the estimate for ADHD prevalence among adults is similar to the worldwide estimates (Espinet, Graziosi, Toplak, Hesson, & Minhas, 2022), it follows that the number of students with ADHD enrolled in college/university in Canada is probably also on par.

Unfortunately, in higher education, having ADHD “adversely affects long-term academic outcomes” (Arnold, Hodgkins, Kahle, Madhoo, & Kewley, 2020, p. 1). Compared to their neurotypical counterparts, college and university students who have ADHD, or who remain undiagnosed but have significant ADHD symptoms, tend to have lower GPAs (Pagespetit et al., 2025), are more likely to drop out in their first year (Stevens, Abu-Ramadan, & Hartung, 2022), and complete fewer years of higher education overall (Canu et al., 2021).

There are many reasons why students with ADHD struggle with post-secondary education. Getting high school grades sufficient to be accepted into a program may make it look like a student is ready for this next step; it's only when they move from home to a less structured environment that the cracks begin to show (Pagespetit et al., 2025).

Among freshmen, deficits in independent daily living skills represent one of the biggest gaps in college/university readiness between students affected by ADHD and those who are not (Canu et al., 2021). Without the daily executive functioning support from parents and teachers, to which they have become accustomed, seemingly simple tasks like keeping track of items they need (keys, books, wallet, etc.), setting up a quiet study space, keeping a regular sleep schedule, eating healthily, and getting to classes on time can prove difficult for students with ADHD just starting post-secondary education (Canu et al., 2021; Pagespetit et al., 2025).

Academic readiness may also be a sticking point. First-year post-secondary students with ADHD tend to be weaker in the skills necessary for academic success, such as studying for tests, note-taking, tracking deadlines, writing papers, and breaking down assignments (Canu et al., 2021).

It's a good thing, you may say, that schools have Accessible Learning departments and other student services to help. Yes. Those services can be very helpful. Academic outcomes do tend to improve for students with some sort of disability when they register for and use disability services/accommodations (Chiu et al., 2019); if students seek out those services. In a national longitudinal study from the United States of 3000 students with disabilities who enrolled in higher education after high school, only 35% informed their college of their disability, with only 24% receiving any sort of official accommodations (Newman & Madaus, 2015).

Why wouldn't students who could receive academic accommodations and supports not do so? When surveyed, students give a multitude of reasons, such as not knowing services existed, difficulty in getting assistance from understaffed departments, cumbersome registration processes, not being able to gather sufficient documentation¹ (Toutain, 2019), and not having access to an affordable assessment process (Pagespetit et al., 2025).

Even if a student does manage to secure accommodations, they may not use them. When students were asked about the barriers to using accommodations, common themes appeared:

- **Issues with faculty:** This could be faculty trying to dissuade the use of accommodations, failing to be discreet when making adjustments, or just refusing to implement accommodations (Toutain, 2019).
- **Accommodations not being available or practical:** Such as needing alternative formats of class materials (e.g. audio textbooks) and finding they don't exist or that the versions available are not compatible with screen readers; or needing the accommodation of having extended time to write tests but having to miss other classes to use it (Toutain, 2019).

1. Or, in the case of mature students, not being able to find old paperwork or access old school records.

- **Fear of social stigma, or stigma from professors:** Even if their current faculty are amenable, negative experiences in the past may dissuade students from utilizing accommodations (Toutain, 2019; Edwards, Poed, Al-Nawab, & Penna, 2022).
- **Anxieties about independence and legitimacy:** After a history of getting support from parents and teachers, students may echo negative messages they have heard, like “accommodations don’t exist in the real world,” and see the use of accommodations as a weakness, or as reducing the legitimacy of their academic accomplishments (Toutain, 2019).

Fortunately, it’s not all doom and gloom for post-secondary students with ADHD. Students who are actively treating their ADHD, pharmacologically, non-pharmacologically², or multimodally, do better in higher education than students who leave their ADHD untreated (Arnold, Hodgkins, Kahle, Madhoo, & Kewley, 2020). It has also been shown repeatedly that students with ADHD who utilize support services at college/university are more successful academically than those who do not (DuPaul et al., 2021; Doyle, Healy, Paterson, Lewis, & Treanor, 2024; Stevens, Abu-Ramadan, & Hartung, 2022; DuPaul et al., 2017). Post-secondary supports that have been shown to be most useful are those that target: “learning and implementing study skills, overcoming procrastination and enhancing motivation to complete aversive tasks, self-monitoring of academic tasks, building confidence in academic abilities, learning and implementing emotional regulation strategies, and encouraging the development of a social support system in college.” (Stevens, Abu-Ramadan, & Hartung, 2022, p. 12).

Now, if only there were some kind of “Specialist” in “Learning” who could assist students in mastery of these skills...

2. I.e. behavioural therapy, ADHD coaching, conscious exercise, etc.

The Growth, Care, and Feeding of This Guide

This guide was written by a Learning Specialist (LS) for Learning Specialists. More specifically, it was written by a Learning Specialist with ADHD for Learning Specialists without.

As a quick internet search will show, there is a mountain of information on ADHD out there. An endless number of websites from sources ranging from postsecondary institutions to government health agencies, to ADHD enthusiast organizations, boast lists of strategies that will help students with ADHD succeed academically. The information across these sites, which is usually free and unencumbered by citations or references, is often so generic and similar that it looks like it could have been hastily generated by AI after a manager requested more resources on their departmental site.¹

The goal of this guide was to wade through as much of the ADHD research² and pop-cultural “knowledge” as possible, and gather the most useful and accurate information into one place for the busy LS.

As you can see from the table of contents, this guide has something for everyone. Feel free to skip around and take what is useful. If you are looking for additional strategies to help your students mitigate common challenges, have a look at the Major Areas of Struggle section. If you are suddenly meeting with a lot of newly diagnosed students who are wondering what an ADHD diagnosis means and what to do next, check out the Newly Diagnosed Students section. If you are wondering what one of your students is talking about when bringing up medication side effects, rejection sensitivity, or seeing an outside ADHD Coach, hit up those sections. Or, if you have trouble sleeping and want some somnambulant bedtime reading that somehow has both too many and not enough citations, you are welcome to start from the beginning and plow through.

This guide isn't the be-all end-all on strategies for working with students with ADHD; there will always be new ideas and new research. As such, a guide like this will never be complete. But this is a start, and since this is an Open Educational Resource, it can be improved and built on by anyone with the inclination and the time.

1. Which some probably were.

2. As it exists as of the spring of 2026.

PART II

ADHD REVISITED

ADHD and Its Discontents

Almost everyone has heard of ADHD and has some idea of what it is. What many people “know” about ADHD, however, is only as accurate as the information swirling around in the pool of common knowledge. And the quality of that information? To steal a word from Japanese, the quality of that information is...“bimyo”. Which is to say, in the politest way possible, not always great.¹

Let’s start by saying ADHD doesn’t look the same for everyone. For an individual, symptoms may not be consistent from one day to the next, let alone present consistently across their lifespan. A hyperactive chatterbox and a spacey daydreamer may each have ADHD. Or they may not. A person with ADHD might be overly attuned to the feelings of others in one situation and (blissfully?) oblivious to all social dynamics in the next. A student with ADHD who gets nearly perfect on a test for unit 13 can inexplicably bomb the test for unit 14, without changing their study habits. ADHD has succinctly and accurately been described as a “syndrome of paradoxes” (Hallowell & Ratey, 2010, p. 12).

While determining the cognitive and genetic workings of ADHD is still an active field, there is a general consensus within the community of ADHD researchers that a main driver of ADHD is inhibition control (Barkley R. A., 2015; Barkley R. A., 1997). As one researcher put it, the “key to understanding ADHD is that many problems labelled simply as ‘difficulty paying attention’ are actually problems with impulse control ... [It’s not only that] adults with ADHD cannot sustain attention. It’s also that they can’t resist the impulse to pay attention to something else that enters their field of vision, or hearing, or thinking” (Barkley R. A., 2021, p. 59).

Like a cascade of marbles tumbling down a stairwell, the cognitive and behavioural issues resulting from problems with inhibition control ping off in all directions. Impulse control issues become problems with executive functioning and self-regulation, which can cause problems in a person’s relationship, job, and education, which can, in turn, cause problems with mental health and motivation, and so on and so on (Barkley R. A., 2021, p. 47).

1. Your intrepid LS author, surreptitiously attending a workshop for faculty, was told by a confident faculty member that most people with ADHD are so impacted by their disability that they can’t get a driver’s license. (The rest of the breakout group nodded in agreement, while your tactful and handsome author tried not to break into incredulous laughter.) To clarify, as of 2026, there hasn’t been much research done on teens with ADHD getting driver’s licenses. Once they have their licences, teens with ADHD do have a slightly increased risk of accidents compared to those without. However, unless the ADHD is comorbid with another disorder like Oppositional Defiant Disorder or Conduct Disorder, the difference in the risk of accident is negligible (Vaa, 2012). For more on where the dubious information on ADHD comes from, see “Accurate Information” in the section on [Meeting with a Newly Diagnosed Student](#).

What We Talk About When We Talk About ADHD

The debate about the existence of ADHD, more prevalent in the 1990s and early 2000s, never completely went away. One still runs across the occasional eye-catching headline proclaiming that “ADHD Does Not Exist” (Saul, 2014). And it’s not uncommon to encounter a staff or faculty member who thinks that students with ADHD “just need to try harder.”

The response from the scientific community to questions about the existence of ADHD was resolute. As a statement signed by 86 doctors from 9 countries put it, ADHD is “a matter of science” (Barkley et al., 2002, p. 89), and that saying ADHD is not real is “tantamount to declaring the earth flat, the laws of gravity debatable, and the periodic table in chemistry a fraud” (Barkley et al., 2002, p. 90).

The modern, more nuanced and interesting version of this debate moves beyond the old it does/doesn’t exist dichotomy to consider what it means to “have ADHD” when the frame shifts from the Medical to the Social model of disability.

In the medical model, disability is seen as the result of an individual’s medical impairment. In this world, disabilities are medical conditions that need to be treated, fixed, or cured. The disability is seen as a defect situated in an individual’s mind or body (Letšosa & Retief, 2018). In the social model of disability, impairments exist, but the “disability” is an external situation created by societal barriers to accessibility and inclusion (Hogan, 2019).

The case for ADHD as a medical problem to be fixed has been institutionally accepted, in Canada and the USA at least, since the term Attention Deficit Disorder was introduced into the DSM-3 in 1980. ADHD is still a “disorder” in the DSM-5; one “has” ADHD, one sees a doctor or psychologist to get diagnosed with it, and one can take medication for it. One can even get accommodations for the disability of ADHD to help with success in school. In the medical model, it’s not the fault of the person that they have ADHD, but it is an affliction that makes life harder for them.

Regardless of how problematic the label of a medical disability may be, there may be some benefit to having such a label for the challenges a person faces every day. For some, embracing the idea that they have a medical condition called ADHD is therapeutic and provides room for self-empathy and self-acceptance (Freedman & Honkasilta, 2017). The past failures and struggles that weigh on their mind weren’t necessarily their fault — they were doing their best; it was the ADHD that was to blame.

Viewing ADHD as a societal issue “move[s] away from the ‘pathology paradigm’— which turns neurodivergence into a ‘mental disorder’ or ‘medical condition’” (Chatterjee, 2024, p. 2323) towards a paradigm where neurodiversity is seen as the norm. In the social model, the disability manifests from the marginalization, oppression, and injustices that neurodiverse individuals face every day (Chatterjee, 2024). As a social issue, ADHD symptoms and behaviours, rather than being signs of individual pathology, are normal and “healthy reactions to inaccessible environments” (Freedman & Honkasilta, 2017, p. 582).

In the DSM-5, ADHD and its long list of diagnostic criteria fall under the umbrella of Neurodevelopmental Disorders. Though the DSM is expressly designed as a tool for the medicalization of ADHD, and presents symptoms in a way that supports the view of ADHD as a medical disorder, if the manual could speak, it would also be telling the reader to “pay no attention to the social issues behind the curtain.”

For every DSM symptom that medically situates the impairments in the individual’s brain and body, such as “Often fails to give close attention to details” (American Psychiatric Association, 2013, p. 60) or “Often fidgets with or taps hands or feet or squirms in seat” (American Psychiatric Association, 2013, p. 61), there are symptoms that come from a conflict between an individual and their social situation, such as “often talks excessively” (American Psychiatric Association, 2013, p. 61), “often runs about or climbs in situations where it is inappropriate” (American Psychiatric Association, 2013, p. 61), or “often leaves seat in situations when remaining seated is expected” (American Psychiatric Association, 2013, p. 61).

This second, social-interaction-based, set of symptoms is more subjective. Meeting one of these diagnostic criteria requires an authority figure to judge what is “expected,” “excessive,” or “inappropriate.” This begs a litany of questions. Whom should that authority figure be? A teacher? A boss? A friend? A romantic partner? How does that person draw the

lines between what is expected and what is too much? Does what is considered excessive or inappropriate change based on the context, or the mood of the person judging? And, who, or what group, is the benchmark for “normal” behaviour to whom the person with the ADHD symptom is being compared?

In one family, a dinner table where everyone interrupts and talks over each other might be normal. At another family’s table, the culture may be turn-taking and silent listening. Drop one person from each of these situations into the other, and suddenly what was normal becomes “often interrupts or intrudes on others” (American Psychiatric Association, 2013, p. 61), or “often does not seem to listen when spoken to directly” (American Psychiatric Association, 2013, p. 60). Do the people who switched families each now have an ADHD symptom they didn’t have before?

Where does this leave us for this guide? Is ADHD a medical problem, or is social problem caused when people don’t fit into existing systems? For the remainder of this guide, we are going to follow the lead of Freedman & Honkasilta (2017). Though we recognise that ADHD exists as a reaction to society’s inability, or unwillingness, to accommodate normal neurodiversity; we also have to accept that “disorders exist insofar as they are recognized as legitimate in discursive practices within social, cultural, and institutional contexts” (Freedman & Honkasilta, 2017, p. 569). Because ADHD is diagnosed by doctors, treated by the layperson as a valid mental disorder, and, most importantly for our purposes, used as a legal rationale to obtain social and educational support (Freedman & Honkasilta, 2017); for the purpose of this guide, that is how we must engage with it.

Finite “Presentations” – Infinite Variations

There are three “presentations” of ADHD according to the DSM-5, each of which can also come with a potential “Mild,” “Moderate,” or “Severe” qualifier (American Psychiatric Association, 2013). It's important to note that each of these different presentations is a spectrum and looks different for everyone. A person diagnosed with one particular subtype may have completely different strengths and weaknesses than another person with that same diagnosis. On top of that variation, one's subtype can shift with age.

Predominantly Inattentive Presentation (ADHD-I)

This type used to be referred to as ADD as opposed to ADHD.¹ The stereotypical version of an inattentive presentation is that daydreamy kid you had in your class when you were young who would sit quietly, presumably paying attention. Then, when the teacher asked them a question, they would startle and say “What?” in a way that made it clear they were a million miles away in their head and had no idea what was going on. A predominantly inattentive presentation is much more than this caricature, however.

Qualifying as “predominantly inattentive” means a person's symptoms mostly fall into areas like: difficulty focusing, getting easily distracted (by stimuli or irrelevant thoughts), forgetfulness, losing things, failing to pay close attention to details, not seeming to listen when being spoken to directly, etc. (American Psychiatric Association, 2013). In the daily life of an adult, the functional impact of predominantly inattentive ADHD might look like: forgetting to run errands, respond to emails, or pay bills; having trouble remembering or showing up on time to appointments or social commitments; repeatedly losing important items like wallets and keys; or not knowing how to drive somewhere they have been hundreds of times before as a passenger.

Commonly, “scattered,” “unreliable,” “untrustworthy,” and “flighty” are the epithets used to describe a person with predominantly inattentive ADHD by those around them. In a heartbreaking erosion of self-esteem, a person with this subtype may eventually use the same words to describe themselves.

Predominantly Hyperactive Presentation (ADHD-H)

This presentation literally puts the H in ADHD. The hyperactive version is characterized by fidgetiness, excessive talking, chronic interrupting in conversation or during activities, impatience, rushing through tasks without paying attention to details, blurting out answers before questions are asked, etc. (American Psychiatric Association, 2013). More common in children, predominantly Hyperactive ADHD in adults is uncommon to rare (Barkley R. A., 2021, p. 35).

“Aging out” of ADHD doesn't happen in a huge number of cases. When it does, it usually occurs when someone with predominantly hyperactive ADHD finds that as they age, their hyperactive symptoms fall away, and what impairments are left no longer hit the diagnostic criteria for ADHD (Nadeau, Littman, & Quinn, 2015, pp. 27-29). The Hyperactive Presentation is theorized by some to be an earlier developmental stage of the more common Combined Presentation (Barkley R. A., 2021, p. 35).

1. For a while, people combined both acronyms when referring to the disorder. You would hear someone say, “When it comes to ADD/ADHD...” Somewhere along the line, people got tired of listing all of those As and Ds, and now we just use ADHD and specify a presentation.

Combined Presentation (ADHD-C)

Estimated to make up 65% or more of clinical cases (Barkley R. A., 2021, p. 35), ADHD-C is by far the most common presentation in adults. True to its name, this presentation bundles all the fun of hyperactivity and inattention together into one messy, paradoxical tangle.

Someone with this presentation might spend a morning fluttering around the house cleaning and doing chores instead of starting on an assignment, spend the afternoon at their desk intent on getting things done, but daydream and stare out the window instead, and then, after dinner, put in six hyper-focused hours of work before collapsing from exhaustion well after midnight. With ADHD-C, every day can be an inconsistent, unpredictable, and frustrating lark.

Getting a Diagnosis (As an Adult)

ADHD doesn't come on suddenly. According to the diagnostic criteria in the DSM-5, some reported symptoms must have been present before age 12 (American Psychiatric Association, 2013). However, even with signs of potential ADHD going back to their childhood, many people don't get diagnosed until adulthood.

There are many reasons why many adults with ADHD manage to go so long without a diagnosis: uninformed teachers and parents, growing up in a culture that doesn't look for or acknowledge learning disabilities, schools that don't have systems set up for testing, symptom presentations that aren't stereotypical, and so on.¹

A person getting diagnosed later in life (after high school) has often been struggling with the effects of ADHD for years through different jobs, attempts at higher education, and relationships. They don't understand why things that seem easy for others (showing up on time, finishing work tasks, keeping promises) are so hard for them.

Unfortunately, if a childhood diagnosis was missed, getting an ADHD diagnosis only becomes more difficult and more expensive after one graduates from the public school system. Even if someone has health benefits from work that will help cover the cost, researching evaluation options, arranging and showing up to all of the necessary appointments, and making sure to complete and submit all of the paperwork requires a level of executive functioning (a weakness for people with ADHD) that can feel so overwhelming that many just give up. It's not uncommon to hear someone say, "I probably have ADHD. I just never got around to getting tested." "Never got around to being tested," could be translated as "the benefits I see in having a diagnosis don't outweigh the cost, or the cognitive and emotional labour it would take to get it."

Below are some of the most common paths for getting a diagnosis as an adult:

Primary Care Providers

This is the cheapest option (free in Canada) because doctors' appointments are covered by provincial healthcare systems. Unfortunately, not everyone has a primary care provider (PCP).² An additional complication is that not all PCPs will diagnose ADHD. Some tell their patients that they need a psychologist/specialist to do the testing and then to come back once they have the results.

Your thorough author asked their personal PCP why some PCPs may feel uncomfortable diagnosing ADHD. They gave a list of possible reasons:

- Adults have often developed coping strategies that mask ADHD, and that can make the diagnostic process difficult.
- The high frequency of mental health comorbidities with ADHD also complicates the diagnostic process, and not all PCPs feel they have the expertise to sort through a series of mental health disorders.
- In the case of students who have recently moved to the area for school, a PCP might not know the patient well, which makes it harder to diagnose something like ADHD, which relies on knowing a patient's history.
- In the last 10 years, there has been a huge influx of people who, having a symptom or two, have been convinced by social media that they have ADHD and that medication is the answer for a more productive and efficient life.

1. A missed diagnosis may also be due to institutional bias. Girls are traditionally much less likely than boys to get tested or diagnosed when in elementary or high school (Williamson & Johnston, 2015). See the section on [Sex, Gender, and ADHD](#) for more information.

2. Or, in the case of students, they may be living far from their PCP.

- Since common ADHD medications are controlled substances, PCPs don't take prescribing them lightly.³

These reasons echo those found in a study examining which medical professionals were confident in diagnosing and treating ADHD. PCPs and other non-psychologists/psychiatrists (NPs) were less likely to diagnose ADHD than doctors who specialized in mental health. A possible reason given for this gap was that less than 10% of the PCP and NP group felt like they were highly knowledgeable and well-trained when it came to diagnosing ADHD (Adler, Farahbakhshian, Romero, Flood, & Doll, 2019).

If a PCP is on board, they will take a history of the patient, making sure to ask about their experiences in elementary and high school, and then send them home with some rating scales. They often ask that the scales be completed by the patient and by others who have known them for a long time, preferably since they were young. The ideal result is to see consistency in symptoms across raters, over time, and across different environments (work, school, life, etc.).

If the rating scales indicate a possible diagnosis, the doctor will discuss with the patient different options for managing the condition. Some PCPs propose trying ADHD medications for a while to see if it makes a difference. If it does, it would further confirm a diagnosis based on the rating scales and case history. If the rating scales come back in an inconclusive grey area, or if there are other complicating comorbidities at play, a PCP may still recommend following up with a psychologist.

Psychologist

A diagnosis from a psychologist is the gold standard for an ADHD diagnosis if one can afford it. Beyond using the same ADHD rating scales as a PCP and taking a detailed history, a psychologist will run a barrage of tests to rule out anything that might be masquerading as ADHD and see if there are other relevant or complicating cognitive impairments.⁴

Students may also want a psycho-educational assessment. Beyond looking for learning disabilities and other cognitive weaknesses, psycho-educational assessments look at how any of these conditions might be affecting a person's learning and education. A regular assessment, without the educational part, is faster and cheaper. The decision on which to do depends on why one is seeking a diagnosis and what documentation one may need.⁵

Accessible Learning/Disability Services departments in post-secondary institutions don't often need a psycho-ed assessment to grant accommodations, especially if a student is seeking more common accommodations. A general rule of thumb is that the bigger the accommodation, the more in-depth the documentation needed to justify it.

Online Diagnosis

A recent trend, which is not as dubious as it sounds, is getting evaluated for ADHD online. This could be a good, cost-

3. Because the most common ADHD medications are stimulants, there is a black market that encourages people to try and get prescriptions for recreation/to sell. Some doctors and drop-in clinics even have signs in their offices or messages on their websites that say, "We don't prescribe medication for ADHD."
4. Issues like anxiety, PTSD, insomnia, and chronic stress can impact concentration, working memory, and emotional regulation in ways that look like ADHD. A good psychologist will try to tease all these threads apart to see what is actually going on.
5. In Ontario, these assessments aren't covered by OHIP and in 2026 tend to run in the \$1500-\$4000 range.

effective solution for students. There is a Canadian company called Frida (www.talkwithfrida.com) which will do an ADHD telehealth/internetty diagnostic process for \$600 (as of 05/11/26). They cover many provinces, but not all of them.

This service conducts initial screenings to determine whether one is a good candidate for its diagnostic process. If their initial screener indicates that one is a good candidate, they will send the same screening forms as a PCP. After those have been returned, they will call the patient for a lengthy phone interview, asking about medical and mental health history, educational history/experiences, functioning in different areas, etc.

Rather than screening for a full spectrum of problems, Frida is narrowly focused on ADHD. If there are complicating factors (ie. other contributing health or cognitive issues), Frida will recommend that the person talk to their family doctor or a psychologist. They try to deal only with straightforward cases. If a person does get a diagnosis from Frida, this service can prescribe medication, if appropriate.

They also do follow-up appointments to check on how the medication is going and if adjustments need to be made; they don't just issue a prescription and then peace out. Post-diagnosis, ongoing care is included for a specified period with the initial package and is an additional expense thereafter.⁶

The only hitch is that if the service has prescribed medication, one has to keep making appointments with them to get it renewed, and each appointment costs money. Some people manage to convince their PCP take over the prescription so they can stop paying Frida for refills. Not all PCPs are happy with such an arrangement.

6. They are a business, after all.

A Later in Life Diagnosis

The impetus to seek a diagnosis could come from some life crisis, like failing a class, losing a job, having a relationship fall apart, or just from seeing something online that hits home. Regardless of the catalyst, finally getting an ADHD diagnosis as an adult can trigger an avalanche of emotions.

For people who have been trying to get a diagnosis for years, it can be validating to get an official thumbs up. For those who are new to the idea of having ADHD, the reaction to getting a diagnosis can range from excitement to disillusionment and demoralization (Barkley R. A., 2021, p. 101). Receiving an ADHD diagnosis means that a person has just found out that they have a condition that will never go away; the things they have struggled with their whole lives will, in all likelihood, remain a struggle.

After getting a diagnosis, the image someone had of themselves as an employee, a romantic partner, and as a person in the world is now suspect. Questions start to bubble up in a newly diagnosed person's mind. Was it the ADHD's fault that they got fired from that job? Was it the ADHD that made their ex frustrated and think they were selfish and thoughtless? Is ADHD an excuse, a crutch, a superpower, a curse? What would their life be like if they had gotten diagnosed earlier? (Hansson Halleröd, Anckarsäter, Råstam, & Hansson Scherman, 2015).

With the new lens of an ADHD diagnosis, there is a balance that each person must find between the emotional work of reexamining and piecing together the broken pottery of past events, and using this knowledge to try to break fewer pots in the future. If someone has been diagnosed recently and is trying to figure out what this means for them, connecting the student with on-campus counselling or therapy services can be very helpful, if they aren't already seeing someone.

Another reason to recommend therapy/counselling is that over 75% of adults with ADHD have at least one other psychiatric disorder (Biederman et al., 1993; Sobanski et al., 2007).¹ The most common comorbidities are: other learning disabilities (Nadeau, Littman, & Quinn, 2015, p. 172), mood disorders, anxiety disorders, personality disorders, and substance abuse disorders (Choi, Woo, Wang, Lim, & Bahk, 2022).

A reason for the increased likelihood of a comorbid mental health disorder may be that people with unknown and/or undiagnosed ADHD spend a lot of energy trying to be "normal." They live with a "pervasive sense of confusion and embarrassment ... They know they are smart enough to be on top of things, yet they mysteriously underachieve, even when they are trying their hardest" (Nadeau, Littman, & Quinn, 2015, p. 172). Having failure and inconsistency be one's constant companion from childhood on, and not knowing why, takes a toll. Compared to people who remain undiagnosed until they are adults, those who are diagnosed and receive help as children are at lower risk of developing anxiety and/or depression as adults (Barkley R. A., 2021, p. 119).

1. It's estimated that as many as 50% of people with ADHD have at least two comorbid psychiatric disorders (Barkley R. A., 2021, p. 255).

Meeting with a Newly Diagnosed Student

When meeting with a student who discloses that they have ADHD, whether the diagnosis still has that new car smell or if it's something they have known about for ages, setting a positive tone from the beginning is important. Success in working with the student is only possible if they see the meetings as a positive, useful, and encouraging space where they can share their struggles without judgment. Teachers, parents, partners, and bosses have been telling them how to “fix” their problems for years – we need to show how working with an LS will be different. To facilitate this kind of tone, there are a few things to bring to that first meeting:

Excitement!

In an effort to move past the negative connotations of “deficit” and “disorder,” try to frame the diagnosis as a net positive. Be excited to meet them. Congratulate them. And if you happen to have ADHD yourself, welcome them to the club.¹ Let the student know that ADHD isn't just about weaknesses. When the downsides are well managed, there are situations when having ADHD can be beneficial.² A common metaphor is that the ADHD brain is like a sports car with bicycle brakes and bicycle steering. Once it gets going, it can outpace most cars on the road – one just has to be mindful of sudden changes in speed or direction.

Empathy

By the time a student finds themselves in a meeting with a Learning Specialist, they have usually been struggling for a while and may be feeling demoralized, ashamed, and/or like a failure. For a student with ADHD, these feelings probably predate their current schooling. Like the student we meet without ADHD, those living with it may need to start by having someone listen to their story with curiosity and empathy.

As this takes time, an initial meeting may not feel as “productive” to the Learning Specialist as they are accustomed. There might not be time to go through each course and map out all deadlines, for example. That's ok. If a student has spent years going it alone at school and hasn't reached out for this kind of help before, having someone listen to them, and knowing they don't have to buffet the storm alone anymore, can be just as reassuring as a filled-out planner.

That said, it is also important to discuss students' goals in an initial meeting. With that info, the LS can discuss what kinds of things have helped students in the past, and the student can think about which strategies discussed might work for them. It's important for the student to leave with a sense of the path forward.

If the first meeting leaned more toward listening and relationship-building, schedule a follow-up meeting as soon as possible to jump in and really get down to work. Meeting again within the week is ideal, especially if there are fires to be put out. After that, a regular schedule should be adequate.

1. If that is something you are comfortable sharing.
2. See the section on [Strengths](#) for more information on this and on why it's best to avoid the “ADHD is a superpower” rhetoric.

Accurate Information

ADHD, until relatively recently, was seen as something that only affected children, with the thought that it resolved as the brain developed between adolescence and young adulthood (Rivas-Vazquez, Diaz, Visser, & Rivas-Vazquez, 2023). The diagnostic criteria in prior versions of the DSM described ADHD in terms of children's behaviour, only adding adult examples and descriptions in the current DSM-5 (Zalsman & Shilton, 2016). It's not surprising then that when many adults are newly diagnosed, the image of ADHD they have in their minds is based on how it presents in children.

Some newly diagnosed adults may have received information from reliable sources, like a doctor or psychologist, but many more, unfortunately, know only what they have gleaned from TV, movies, and social media. A 2022 study looking at TikTok noted that ADHD was the platform's seventh most popular health-related hashtag (Yeung, Ng, & Abi-Jaoude, 2022). The study also found that much of the information people were getting from those tagged videos was inaccurate. 52% of the ADHD tagged videos were not medically accurate or made unsubstantiated claims, and 27% were personal accounts with few medical claims. Only 21% were deemed to contain accurate medical information (Yeung, Ng, & Abi-Jaoude, 2022). A previous study observed similar trends on YouTube (Thapa et al., 2018).

When talking to a Learning Specialist, a student may be trying to better understand ADHD and what having it means for them as an individual and as a student. A Learning Specialist doesn't need to be an expert, but they should be an accurate source of information for students. This guide will hopefully provide some of that background.

An Air of Normalization, Fraternity, and Hope

When a person is diagnosed with ADHD as an adult, they have often spent years wondering why things that seem so easy for other people have always been so hard for them. It can be an isolating experience.

When a student brings up something with which they are struggling, it can be reassuring to know that many other people with ADHD also struggle with that exact same thing (e.g. forgetting things, having difficulty focusing on boring topics, chronic procrastination, etc.). As an LS, if you have worked with previous students with ADHD who struggled with similar issues, mention it.³ Knowing they aren't alone is important.

It can also be heartening to know there are scores of other students with ADHD who, through long processes of trial and error, have figured out successful strategies and workarounds to deal with every imaginable problem. You have probably seen this with your previous students – mention it. Let the student know that your work together is one way to accelerate the trial-and-error process and help them find sustainable strategies that work for them as quickly as possible.

3. Anonymously and generally, of course.

PART III

MAJOR AREAS OF STRUGGLE AND
COMPENSATORY STRATEGIES

The Kinds of Strategies People Use

As any LS can tell you, many students who have jumped into the post-secondary pool haven't been given either the prerequisite support or the opportunity to develop the skills needed to stay afloat in post-secondary education. That doesn't mean they are doomed; they can still learn the skills necessary to become academically successful. Especially if they have some help.

One group of ADHD researchers looking into the success strategies of post-secondary students with ADHD noted that, "in order for some adults [with ADHD] to effectively use compensatory strategies, they may require additional support" (Kysow, Park, & Johnston, 2017, p. 81). Regular meetings with an LS are a great way for students with ADHD to get this support while they learn to become more independent in using compensatory strategies.

In studies where adults are asked how they manage their ADHD symptoms, their responses generally coalesce into the following categories:

Adaptation Strategies – These involve altering tasks, demands, or the working environment to better suit an individual's ADHD symptoms (Kysow, Park, & Johnston, 2017). Picture a student changing an assignment to make it more interesting or a workspace to be less distracting.

Attention/Focus Strategies – These are centred on being mindful of one's attention/focus struggles and either compensating by force of will or meeting the brain's need for stimulation in non-distracting ways (Kysow, Park, & Johnston, 2017; Canela, Buadze, Dube, Eich, & Liebreinz, 2017). This could look like exercising before class, working with headphones on in a coffee shop, or just practicing being more aware of when one's attention drifts and working to bring it back.

Organizational Strategies – These are usually the tools and structures put in place to support executive functioning deficits (Kysow, Park, & Johnston, 2017; Canela, Buadze, Dube, Eich, & Liebreinz, 2017).

External Strategies – These encompass the use of medications, recreational substances, and support from other people (therapists, parents, partners, teachers, co-workers, LSs, etc.) to meet one's goals (Kysow, Park, & Johnston, 2017; Canela, Buadze, Dube, Eich, & Liebreinz, 2017).

Avoidance Strategies – This kind of strategy is not always helpful, academically speaking. Avoidance strategies tend to be negative and result in behaviours such as procrastination or avoidance of schoolwork. Avoidance strategies can be positive if someone is using them to avoid getting into situations where they know their ADHD symptoms might cause problems or make it difficult for them to meet their goals (Kysow, Park, & Johnston, 2017). An example of this would be someone wisely deciding not to apply for a job that requires high-level time management skills if they know they have struggled with such tasks in previous jobs.

For the most part, the kinds of strategies people used to deal with their ADHD symptoms as children resemble the strategies they use as adults (Kysow, Park, & Johnston, 2017). One exception is people who relied heavily on social-based external supports as children. These people tend not to rely on those strategies as adults. The theory is that "perhaps as children mature, they transition from relying upon external support, provided by their parents or teachers, to using compensatory strategies independently" (Kysow, Park, & Johnston, 2017, p. 81).

The following sections cover some of the common areas of struggle for post-secondary students with ADHD, and offer targeted strategies that may help.

PART IV

STRATEGIES: PROCRASTINATION AND GETTING THINGS DONE

Procrastination

“Why can’t I just get started?”

Everyone procrastinates – People with ADHD are just better at it than everyone else. Seriously, though, when asked about procrastination, people with ADHD often describe an overwhelming and crippling sense of doom that rolls in when they have to start on something new – even if they know what to do (Hallowell & Ratey, 2010, p. 119).

To try and imagine that feeling, picture the thing that you are most afraid of – heights, spiders, public speaking, cold calling people, whatever. Then imagine that doing that task, or engaging with that thing, is an important part of your job. Your boss will be checking in regularly to make sure it gets done, and if you can’t do it, you will lose your job and not be able to pay your rent, bills, etc.

Now, since you know what to do, and you know it’s really important, get started... Why haven’t you gotten started yet? Your coworkers aren’t having a problem with this, why are you?.... What do you mean you haven’t started yet? People are waiting for you to finish your part, and it should have been done yesterday! Do you even care about keeping this job? Because if you can’t do this, we will find someone who can!

Have the panic, guilt, fear, and shame kicked in yet? All those emotions (and more!) are encompassed in the feeling of doom described by students with ADHD.

While “procrastination” is not explicitly listed as one of the symptoms of ADHD in the DSM-5, many of the Inattentive symptoms are procrastination-adjacent. Symptoms like:

- “Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)”
- “Often has difficulty sustaining attention in tasks or play activities.”
- “Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)” (American Psychiatric Association, 2013).

In terms of how the LS can help, most of what we can offer are versions of our regular procrastination-busting strategies, just turned up to 11 (Tufnel, 1984), and tweaked to fit the student’s particular ADHD symptomology.

As far as helping with the overwhelming feeling of doom, unfortunately, beyond being supportive and encouraging, LSs are limited on that front. These kinds of feelings are probably best addressed with a therapist or counsellor.

Breaking Assignments into Pieces (to the Extreme!)

(Organizational/Adaptation Strategy)

Breaking projects into smaller pieces can make them seem less overwhelming and make starting easier. A manual for using cognitive behavioural therapy to help treat ADHD recommends students use the maxim: “If I feel overwhelmed, then the first step is too big” (Knouse, 2014, p. 767).

Breaking an assignment into smaller pieces isn’t anything new as a learning strategy. An adjustment for a person with ADHD is that they may benefit from having those smaller pieces broken into even smaller ones – micro pieces (Hallowell & Ratey, 2010, p. 119). These small pieces may become so granular as to look like step-by-step instructions – which might be exactly what is needed.

Take, for example, a Graphic Design student with ADHD your fragmentative author once had the pleasure of working with. On their to-do list, the student had the final steps of their project listed as: “Finish mock-up, take pictures, and post photos to the Dropbox.” Historically, these kinds of general steps hadn’t helped the student move past their procrastination. The steps were too big, and they would become overwhelmed and give up. After some work, the more effective version of the list became:

1. Before leaving campus today, go to the studio and print graphic on the large-size printer
2. Take the bus home and get off early at the Dollar Store to buy supplies for the packaging mock-up.
3. Go home and attend synchronous class.
4. After class, cut out the printed graphics and make copies for packaging
5. Use Dollar Store supplies to make the mock-up bubble pack
6. Before gluing it together, insert the product card
7. In the morning, take pictures
8. Post pictures to portfolio and upload it to the Dropbox before leaving for school.

In the example above, the student had a hard time generating these more minute and delineated steps. It was your dogged author’s job to press them for details and specifics by asking guiding questions like: “What do you have to do to finish the mock-up?” “What would be the first step you would have to do for X part?” and “Do you have to do this at school, or can you do it at home?” As the student talked through the sequence, it was helpful for your fleet-fingered author to transcribe the list so the student could focus on the cognitive work of breaking each step down.

Engineering the Environment

(Adaptation Strategy)

As LSs, telling students to remove the distractions from their workspace is procrastination 101. For someone with ADHD, removing all distractions is an impossibility; they could find anything from a water stain on the ceiling to the birds tweeting outside the window could be incredibly distracting. Rather than trying to eliminate all distractions, the target for someone with ADHD should be more along the lines of engineering one's environment to minimize ADHD's potential impact (Hallowell & Ratey, 2010, p. 219).

The first step in adapting one's environment would be to identify the most common ways the environment affects one's ADHD while working. It can help to have an outside perspective (of say an LS) when trying to identify potential issues. The second step would be to identify changes that could minimize problems without creating new ones. There are no pre-fab solutions, however. The ideal work environment is very idiosyncratic, and helping a student find what works for them can be a constantly evolving, never-ending project. Below are some examples of adaptations students could make:

- Soundproof home workspaces as much as possible.
- Carry foam earplugs to use when away from one's home workspace. They are a cheap and effective way to block ambient noise and can also come in handy for in-class work periods or during tests.
- At home, move one's desk to face a wall instead of an open door or window.
- When working at home, move as far away from other people and distractions as possible. If that isn't possible, then consider working somewhere outside of the house (like a library).
- If one works best in a study group, set one up.
- If it is possible to work offline, unplug the internet for a while.
- Strand oneself in boring places where there is no option but to do schoolwork (i.e., purposely missing a bus on campus and having to wait an hour for the next one, or staying at school if there is a long gap between classes).
- Have a trusted person change one's social media passwords temporarily, or hold one's phone, until a work goal is reached.
- Use a white noise machine (or a white noise app on a phone) to cover unwanted sound. Putting on non-distracting music can serve the same purpose.

Social Obligations

(External Strategy)

Some people work best when they put themselves under a social obligation (Hallowell & Ratey, 2010, p. 219; Barkley R. A., 2021, pp. 133-8). The goal is to create a situation that generates just enough social pressure to be motivating, but not so much that it becomes a problem. This strategy may not be best for people who already struggle with anxiety. For these people, adding a social obligation can increase already high anxiety levels and lead to even more procrastination.

To be effectively motivating, the social pressure must be tailored to the person and the particular situation. Despite what some app developers would like you to believe, there isn't a cookie-cutter or gamified version that applies to every situation. Since designing effective social obligations requires creativity, specificity, and a high level of self-awareness, meeting with an LS who knows them well can be very beneficial for the student.

Here are some examples that could be adapted or used as jumping-off points:

- A student could make goals explicit and make them public. They could do this by telling friends, family, and anyone who will listen what they intend to finish by what date. (Keeping these goals private makes them too easy to change.)
- A student could engineer social pressure and activate “good guilt” by making commitments to groups, teachers, or other people who matter. Not wanting these people to think badly of them can be really motivating.
- If they need an extension on an assignment, a student can give the teacher a firm date by which they intend to have it finished.
- A student could have someone to check in on a particular date to ask if the goals they stated have been met, and if they haven't, ask what happened. An LS could do this by emailing a student on a Monday and asking what they accomplished over the weekend. In this case, it would be important not to chastise the student if they didn't achieve their goals. Just ask neutrally what happened and then work with them on a new plan if needed.

Harnessing Interest to Spur Action

(Adaptation/Focus Strategy)

Dr. William Dodson, a longtime clinical psychologist specializing in ADHD, talks about the nervous system of people with ADHD working differently from those without. He metaphorically refers to an “interest-based nervous system” for people with ADHD vs. an “importance-based nervous system” for those without¹ (Dodson W. W., 2006).

The crux of the idea is that just because a task is important, that doesn’t mean students with ADHD will feel compelled to do it.² “Stimulant medications are very good at keeping the ADHD brain from getting distracted once they are engaged, but they do not help you get engaged in the first place” (Dodson W. W., 2024). For someone with ADHD, according to Dodson, interest, challenge, novelty, or urgency are needed for a person with ADHD to take action (Dodson W. W., 2006).

The trick then, for most students with ADHD, becomes how to make the boring schoolwork interesting enough that they will want to engage with it in the first place.

“Limbic tagging” (Gualtieri, 2002, p. 9) is the term another researcher gives to the transubstantiation process of rendering the dull engrossing by making it meaningful. This theory involves using the limbic system, which is involved in the regulation of emotions (Kaushal, Saran, Bazaz, & Tiwari, 2024), to spur action in the prefrontal cortex, which is involved with executive functioning, focus, and concentration (Friedman & Robbins, 2022). If one can trigger an emotional response to a task, be that excitement, pride, curiosity, competitiveness, or even spite, it can make that task easier to focus on.

Whatever the mechanism, helping a student find ways to make schoolwork exciting or meaningful is a highly individualized process; the watchwords are: interest, challenge, novelty, and urgency.

Examples/ideas:

- The student could ask their faculty if it would be possible to shift the focus of the assignment to a topic about which they are interested or have a strong opinion. Professors often admire the initiative as long as the proposed assignment covers the same learning objectives.
- A student could choose to focus their project on topics or opinions that they disagree with or think are wrong. Tearing someone else’s ideas apart is an easy way to stay motivated and interested. This can also work for readings. It can be easier to stay focused if a student goes into a reading with a skeptical mindset, looking for mistakes in logic/reasoning, and seeking to make the author convince them of their expertise.
- A student could find the part of an assignment they find the most interesting, start with that, and ride the wave of that momentum to the less interesting parts.
- A student could make the class work an unspoken competition with a classmate or classmates. (E.g., can the student be the first one each week to post to the discussion thread?)
- In a group project where other members aren’t pulling their weight, the student, out of spite, could try to make their contribution to the group presentation so good that it will make plain how little the others contributed.

1. For Dodson, these categories are based on clinical observation rather than documented cognitive differences

2. Unless, maybe, there is the extrinsic motivation of an urgent, crushing deadline.

Environmental Cuing

(Adaptation Strategy)

There was a fun study on prospective memory in which participants were asked to come up with several goals/tasks they wanted to accomplish over the next few days. They were to follow up with the researchers by phone at a specific time to check their progress. Expectedly, people with ADHD were twice as likely to forget to call on time (or at all), and when they did call, they were less likely to have made progress on their stated goals. The twist was that this lack of progress wasn't due to a lack of motivation or to the amount of work being overwhelming. The most common reason why people with ADHD hadn't reached their goals was that they didn't remember what goals they had set to begin with (Altgassen, Scheres, & Edel, 2019). One solution to this kind of forgetting is to harness the power of environmental cues as reminders of intended action (Hallowell & Ratey, 2010, p. 220).

Setting a goal intention (e.g., I want to study for 1 hour each day from now until the exam) can boost motivation (Pychyl, 2013). To increase their chances of taking action, one can use environmental cues to prompt their memory by setting an "Implementation Intention." Using implementation intentions has been shown to increase the likelihood that someone will meet an intended goal (Pychyl, 2013, p. 67).

Implementation intentions have 3 parts: a goal, specifics of the intention, and an environmental cue/trigger. Trying to set an environmental cue means one doesn't have to rely just on memory (an internal trigger) to remind them to act; they can instead rely on something in the world. The classic example is someone who says they want to floss daily. Setting the goal and really wanting to do it will be enough for some people.¹ To use an implementation intention, one could say, "If I find myself putting toothpaste on my toothbrush [the environmental cue] at night when I am getting ready for bed [the specifics of when and where], then I will stop what I am doing and floss [the goal]."

The best environmental cues are those that interrupt routine and cannot be ignored. In the example above, it might be better to move one's toothbrush earlier in the day, or the night before, so it's not in its usual location. Then, when one is absentmindedly going through the regular bedtime routine, and the toothbrush is missing, that interruption would be the cue to remind one of the intention to floss.

Your bushytailed author once worked with a student who, each night, would diligently make a to-do list for the next day, only to wake blurry-eyed, launch into their morning routine, and forget the lists even existed. This student found that putting their to-do list next to their coffee maker at night was an effective environmental cue that ensured they would look at it before planning their day.

Sticky notes can be useful environmental cues (Hallowell & Ratey, 2010, p. 318; Barkley R. A., 2021, p. 93), as can phone and computer alerts. Some people with ADHD even take their tendency to forget into account and set several alarms for a single event at different intervals (a week in advance, 2 days, 2 hours, etc.).²

1. But not enough to make dental hygienists happy.
2. All phones and digital calendar apps do some version of these reminders. As of late 2025, among the big 3 (Google, Apple, and Microsoft), Google Calendar is the most flexible across platforms in terms of when and how many reminders (alerts) one can set. Unlike some others, it tends to allow a person to set several reminders for the same event at different intervals and receive them via phone alert, computer pop-up, or email. It should be noted that the capabilities of these platforms often differ across their online, desktop, and mobile offerings. A phone version might only allow one reminder to be set, while the online version of the same program might allow numerous.

Body Doubling

(External Strategy)

Anecdotally and clinically, people claim that body doubling, or co-working, can help a person with ADHD complete nonpreferred tasks (Hallowell & Ratey, 2010, p. 301). Body doubling has been defined as “using the company of others (can be co-located, remote, strangers or people we know) to stay focused on specific tasks (of any domain)” (Eagle, Baltaxe-Admony, & Ringland, 2024, p. 12). Unfortunately, as a 2024 study concluded, although it’s wildly popular on social media, there really isn’t solid evidence to support its efficacy (Eagle, Baltaxe-Admony, & Ringland, 2024).

Despite the lack of supporting evidence, researchers found that once the definition was provided, many neurodivergent participants who hadn’t heard the term before reported having used the body doubling strategy previously (Eagle, Baltaxe-Admony, & Ringland, 2024). Given its anecdotal popularity and its current buzziness, we are going to have a quick look at how body doubling might work with ADHD.

People with ADHD often talk about boredom as if it were an unpleasant physical sensation to be avoided at all costs.¹ Some people find working on a boring assignment or task can be made tolerable by body doubling. Beyond just having company, the social pressure/accountability of thinking that someone might judge you if you are off task can also be a strong motivator.

Body doubling doesn’t even require the Doubler to be physically present or to be doing the same task. Your hermetic author once worked with a student who, to help her finish chores like cleaning her apartment and folding laundry, would schedule a call with her father and then with him over speakerphone while she worked.

Having someone on the other end of the phone, even if they weren’t talking, was all the support she needed to tick those things off her to-do list. If things were stalling and she felt she needed an extra push, she would have her dad occasionally ask her what she was working on and how it was going.

Body doubling could also look like:

- A study group where everyone is working “together” on different assignments or projects.
- Co-working online with a friend or classmate, where each person has their camera on, shares their screen, and then works on their own thing silently for a period of time.
- Staying after class (or coming in early) and working in the library, where other students are also working.
- Using a second monitor on which to put a virtual body double or a live stream of someone else working and then working alongside them.

Body doubling can also leverage social obligations to increase effectiveness. To engineer and maximize that kind of gentle social pressure:

- The Doubler should know why they are there.
- The person with ADHD should outline their goals and share them at the outset.
- The Doubler should monitor the interaction. If progress towards goals isn’t being made, or if having another person there is proving a distraction, The Doubler should call it out. If pointing out the problem doesn’t fix it, then the Doubler should leave. They are neither there to be a distraction nor an enforcer.
- For the co-working option, it can be helpful to have periodic, or wrap-up, check-ins where each person tells what

1. An online article on ADDitudesmag.com asked people with ADHD to describe what boredom feels like. The responses were very descriptive and visceral: “[It feels like] my brain is screaming at me.” “[It’s] like wearing an itchy coat but you can’t scratch.” and “[It’s] like being trapped and cornered.” ([It’s Borture! What ADHD Boredom Really Feels Like, 2024](#)) Check the article out for more colourful analogies.

they have accomplished and evaluates how well the session worked that time. This helps keep everyone accountable.

PART V

STRATEGIES: TIME MANAGEMENT AND ORGANIZATION

Time Management and Organization

“I just keep it all in my head.”

Treatment manuals for therapists working with people with ADHD usually lay out a sequence of topics or modules to cover with a patient. As many treatment manuals are based on CBT, they often stress the importance of beginning the first session with “psychoeducation” or talking about a patient’s motivation for change. The next topic is almost always something called “time management,” “organization,” or “organization and planning” (Solanto, 2011; Safren, Sprich, Perlman, & Otto, 2017). Some guides even view setting up an organizational system as so essential that, initially, after the psychoeducation and motivation-to-change discussion, they try to shoehorn in the introduction of a calendar and a task list system (Knouse, 2014).

The designers of these clinical treatment manuals must have seen the same time management (TM) issues that LSs encounter with their students: namely, that when people don’t have time management systems in place, they try to hold everything in their head, and this frequently results in forgetting important meetings, appointments, and deadlines. For someone with ADHD, the cognitive effort of years spent trying to remember everything, coupled with knowing one’s track record of forgetting, can result in people with ADHD being perpetually enveloped in a miasma of low-level stress and panic that affects every part of their life.

It’s no wonder that the comorbidity between ADHD and anxiety disorders is so high. The prevalence of anxiety disorders in adults with ADHD is estimated to be between 25-50% (D’Agati, Curatolo, & Mazzone, 2017). It seems that the longer a person goes undiagnosed, straining against inaccessible structures and environments, with no explanation for their daily struggles and failures, the higher their risk of comorbid anxiety and/or depression (Barkley R. A., 2021, p. 119; Nadeau, Littman, & Quinn, 2015, p. 172).

For someone who constantly feels like they are scrambling to keep on top of everything, implementing a time management/organizational system can free them from the responsibility of relying solely on their memory. It’s like a window has been opened, giving the worry and anxiety a chance to dissipate, and helping one feel like they can breathe again.

Keep Organizational Systems Simple

(Organizational Strategy)

People with ADHD know what they need to do to stay organized. They know about schedules, calendars, and to-do lists. They probably don't need to be reminded how helpful it can be to write their deadlines into a planner. In fact, it's not uncommon for a person with ADHD to have several to-do lists, calendars, and schedules floating around at any given moment. A computer-savvy student with ADHD will usually be able to list a string of apps, programs, and organizational systems they have earnestly tried, but no longer use.

For many with ADHD, figuring out a novel way to solve the organizational puzzle or learning a new piece of organizational software can be fun, stimulating, and often more interesting than schoolwork itself. It's one of life's cruel ironies that for someone with ADHD, using and maintaining such a system day after day, no matter how beneficial it may be, can feel arduous, boring, and monotonous (Donfrancesco et al., 2015).

A study looking at the different kinds of strategies people use to help manage their ADHD found that the majority of "failed" strategies were organizational (Kysow, Park, & Johnston, 2017). Unfortunately, knowing about various time management and organizational tools, or even trying them out for a while, doesn't necessarily translate into their successful use.

The most powerful thing that a person with ADHD can do to keep organized is to keep any organizational systems as simple as possible (Hallowell & Ratey, 2010, p. 318), and focus on consistency. This is where the LS can help. The accountability of a weekly LS meeting can help a student establish a routine using whatever organizational system works best for them.

Once a system is set up and the student is in the habit of using it, there might come a time in a meeting when the student sits down and does all of their planning and organizing on their own while the LS looks on. This can leave the LS wondering why they even need to be there, as it seems like the student no longer needs help. And they may not – or at least not directly. For some students with ADHD, the routine of having a scheduled time to sit down with someone and make sure they do this planning is an important part of the process. The meeting is a way of creating a social obligation that motivates them to do the planning work.¹

There may be some students who have developed the skills and systems needed to manage their time and stay organized independently but still want an LS meeting. For students who might need a little push out of the nest, an LS can help them build confidence (while still having access to support) and, over time, spread out the frequency of their meetings.

1. It may also be their way of utilizing body doubling. See the earlier sections on [Social Obligations](#), [Body Doubling](#), and [Engineering the Environment](#).

Making Time Tangible

(Organizational/Adaptation Strategies)

Time perception deficits are common for people with ADHD, but how they manifest differs from person to person. Is it time discrimination (perceiving and comparing time intervals) that a student struggles with? Time estimation? Or, most likely, a mix of the two? (Barkley, 2021, p. 96).¹

Until very recently, the research supporting the claim that people with ADHD have time perception issues was far from conclusive. It was complicated by the fact that time perception has many aspects that can be measured in different ways.

A large 2024 meta-study tried to take an expansive view and settle the matter: “Our results suggest medium-to-large impairments in ADHD temporal perception relative to neurotypical controls” (Metcalf, McFeaters, & Voyer, 2024). The hope of this paper was to move the field beyond the question of whether a deficit exists, so that the research community can start examining what might moderate these deficits and how to mitigate them.

One finding of this meta-study was that even though the time perception of someone with ADHD often improved with age, it still tended to fall into the deficit range compared to neurotypical subjects (Metcalf, McFeaters, & Voyer, 2024). The researchers also noticed an unexpected, but unsurprising, correlation: the more trouble a person had with working memory, the more trouble they also had with time perception (Metcalf, McFeaters, & Voyer, 2024).

For our purposes as LSs, the takeaway is: if a student with ADHD comes to see us about time management issues, there is a decent chance they are also dealing with a cognitive time-perception deficit of some kind. How that deficit manifests and what compensatory strategies (internal and external) a student develops to deal with it as they age will be unique (Metcalf, McFeaters, & Voyer, 2024).

Some people with ADHD and temporal perception issues wind up with houses filled with clocks, some set alarms for everything, and others live by colour-coded visual calendars. In all of these strategies, the common element is finding some way to externalize their perception of time (Barkley R. A., 2021, p. 99). This could take the form of a planner, where a student blocks out their daily or weekly schedule to see how much time they actually have for schoolwork. Or it could be a visual timer that shows the time left as it counts down.²

Helping a student find effective time perception strategies can get personal. It usually involves asking a lot of questions about the student’s life, their daily habits, and their rationale for doing/not doing things. It may not be something that an LS or the student is comfortable with until they have worked together for a while and built a trusting relationship.

Your overcompensatorily punctual author once worked with a student who was doing well in school, but was neglecting life tasks like doing laundry, watering plants, grocery shopping, and her share of the housemate cleaning tasks. She said it felt like those things would take hours, and that she couldn’t spare the time because of her heavy school workload. Predictably, having her life outside of school in a constant state of chaos generated so much stress and anxiety that it affected her schoolwork anyway.

A strategy that worked with this student was something called “time tracking.” This strategy can be particularly effective when a student overestimates or underestimates how long something will take. Done consistently, time tracking

1. Time blindness is a vague term oft heard in ADHD circles, in clinical accounts, and in ADHD social media. The examples given are usually about a person starting a preferred task and, 5 hours later, looking up to realize they have missed their class. For the purposes of this summary, we will roll “time blindness” into the larger discussion of time perception issues.
2. A quick online search will turn up a multitude of visual timers, both physical and digital, for purchase. The built-in iPhone timer can also be used as a visual timer. One view of the IOS timer shows a coloured ring around the countdown numbers that represents the time left by retreating counter-clockwise as the time runs down.

can help someone calibrate their time estimation abilities to match reality (Barkley R. A., 2021, pp. 171-177). Like most TM strategies, it is easy to do, but it needs to be done consistently to have a noticeable effect.

To start time tracking, a person makes a chart like the short example below, listing the tasks they want to get done and an estimate of how long each will take. Then, they time themselves doing those tasks and record how long each took. If the estimated and actual times are radically different, then the person has to reflect on why that might be and how to close that gap. A Learning Specialist can be helpful with this reflection process.

Task	Estimated Time (prediction)	Actual Time	Reasons for the difference?
Watering plants	45 min	15 min	I have a lot of plants to water, but it doesn't actually take that long. Especially if I use a big pitcher so I don't have to go back to the sink very often.
Weekly Math HW	1 hour	2 hours 15 min	The questions each had way more steps than I thought. I should have had a closer look at a few before making a time prediction.

As a person consistently tracks their time, the goal is for their predictions to become more accurate and for them to recognize and change unproductive patterns. In the case of the student mentioned above, time tracking revealed that watering her plants and finishing her laundry took her much less time than she thought. She really didn't have to sacrifice time from her schoolwork to accomplish those tasks. After this, she moved on to see how long it actually took her to eat breakfast and how long it took to clean the bathroom.

On the other hand, if a student regularly underestimates how long school tasks take, it often means that they aren't thoroughly looking through assignment instructions, or they aren't taking time to consider the number or complexity of an assignment's subtasks before planning their time. An LS can help this kind of student practice breaking larger tasks into smaller pieces before they try estimating the time needed for each of these individual steps.

Another student with ADHD, your chronometric author worked with, was trying to squeeze all their homework into the evenings after classes, despite having no classes in the mornings. In the evenings, when they sat at their desk, they were usually tired from a day at school and never got through as much homework as they planned. After a few weeks of this, they were falling behind. The student claimed they couldn't do schoolwork in the morning because when they did, they would get wrapped up in whatever they were doing and lose track of time.³ This had happened several times, resulting in the student being late for work and getting in trouble with their boss. Time discrimination was their issue.

With the help of your chronically discriminate author, the student figured out how much time they needed to get ready and when they needed to leave to catch their bus (including a buffer for the unexpected). Then, they set several alarms on several devices to remind them of when they needed to stop working and get ready to leave. The student began by trying this system once a week, with the goal of expanding it to other days if it was successful. After a few weeks, the student hadn't been late to work once, and they were surprised by how much they could get done in the morning when they weren't worn out from a day at school.

3. See section on [Hyperfocus](#).

Scheduling Based on Energy Level

(Organization/Adaptation Strategy)

There are a few common patterns when it comes to energy/attention level and productivity for people with ADHD. The DSM, in the section on ADHD, describes people feeling “on the go,” “acting as if ‘driven by a motor,’” or “unable to be or uncomfortable being still for extended time” (American Psychiatric Association, 2013). It says that others may observe people with ADHD as “being restless or difficult to keep up with” (American Psychiatric Association, 2013).

After these periods of intense activity, a person with ADHD may experience burnout and struggle to focus or get things done. For a student, being “on the go” may look like running around all day, going from class to class, or task to task, until they collapse in the evening from physical or mental exhaustion. When this happens, all best laid plans for doing schoolwork go out the window.

Scheduling breaks or transition times can help avoid burnout and the feeling of being “driven by a motor.” These breaks don’t have to be anything big. It could be taking a walk, pausing for lunch between classes and work, or scheduling “blowout time” (Hallowell & Ratey, 2010, p. 318). “Blowout time” is how some people refer to breaks that are completely “unproductive” and unrelated to school or life obligations, such as playing video games, scrolling on a phone, exercising, or being social with friends.

Scheduling breaks isn’t a work/life balance silver bullet, as it can sometimes generate as many problems as it solves. Another of the ADHD diagnostic criteria reads, “Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort” (American Psychiatric Association, 2013). For a student with ADHD, what starts as a 10-minute break can easily turn into a procrastination-fueled hiatus that stretches into several hours, or into the rest of the day.

After a lifetime of experiencing the negative consequences of distraction and procrastination, many people with ADHD find scheduling “unproductive” time non-intuitive and scary. The worry is that a short break will turn into a long break, and a long break will sprawl out for the rest of the day, and nothing will get done (Hallowell & Ratey, 2010, p. 318). However, without a plan, a person with ADHD may find themselves oscillating between the extremes of not taking enough breaks and taking too many breaks.

The process of selecting break activities that won’t become distractions requires a high level of self-awareness on the part of the student. An LS can help the student pinpoint which activities actually help them recharge their batteries versus which, though they may be a break from school, will wear them down further.

For students who feel guilty when not doing schoolwork, scheduling specific break times and preplanning relaxing activities might be necessary. As with solutions to time perception issues, helping a student discover what kinds of breaks/transitions work for them requires creativity and personalization. Obviously, timers (pomodoro style or phone reminders) can help students regulate break times; however, there are no cure-alls.

An LS can help students with ADHD reflect on and decide on the most effective break/transition options. If a student isn’t terribly self-aware or self-reflective, asking strategic/probing questions like the ones below can help facilitate this process:

- What kinds of activities actually give you energy vs draining it further?
- Are you the kind of person who finds that exercise or going outside helps clear your mind?
- Would taking a break on a screen or off a screen be better for you?
- Is it just your brain that needs to check out, or are you physically exhausted and would benefit more from a sedentary break, or a nap?
- Is there something you could do for a break that has a natural end time?
- If watching videos on your phone is your break, when was the last time you watched only one or two and then turned your phone off and got back to work?
- How are you going to make yourself stop scrolling social media after 10 min when the company designs the app to make that difficult to do?

PART VI

STRATEGIES: MEMORY ISSUES

Memory Issues

“Whoops. Sorry, I forgot.”

In terms of time management and organization, memory deficits affect everything from keeping track of deadlines and appointments to knowing where that pesky to-do list went. Having a thought or a plan and immediately having it pushed out of one's head when the next thought rushes in is a way of life for people with ADHD. It's a reason people with ADHD can end up procrastinating accidentally – they can literally forget their intentions. Adults with ADHD have been found to have deficits in areas of working memory (non-verbal and verbal), prospective memory,¹ and retention of information over time (Barkley, Murphy, & Fischer, 2008, pp. 432-3; Altgassen, Scheres, & Edel, 2019).

The key to addressing memory issues in ADHD is externalizing information usually held in memory. The following strategies explore externalizing various kinds of information across different contexts.

1. For more on the impact of Prospective Memory and forgetting intentions, see [Environmental Cuing](#).

Only Handle it Once (OHIO)

(Organization Strategy)

A person with ADHD might have a plan to do something later, but the combo of distractibility and working memory weaknesses is like a perpetual sleight of hand trick that can make even the best of intentions disappear without a trace. It's an oversimplification, but not an inaccurate one, when people say, "In the world of ADHD, there are only two times: there is **NOW**, and then there is **NOT NOW**" (Dr. Edward Hallowell and the Hallowell Centers, n.d.). The only handle it once strategy (OHIO) starts by accepting one's absentmindedness and knowing that if a task isn't dealt with in the moment, it will likely be forgotten (Hallowell & Ratey, 2010, p. 318). Papers will be lost, emails will get buried, and texts that don't need immediate responses will immediately be forgotten.

The idea behind OHIO is that if one deals with a task immediately, forgetting to do it later won't be an issue. Putting deadlines in the calendar as soon as one hears them, reading through an assignment sheet when it is handed out, or writing a quick email response immediately can be good OHIO habits for a person with ADHD to get into.

Where this strategy spills into other memory strategies is when something can't be dealt with in the moment because it will take too long or would interrupt a task already in progress. In situations like this, "handling it" can mean strategically setting up a plan to deal with a task later. An example would be starting an email draft and leaving it open on the screen so that one sees it periodically and is reminded to finish it. Reading a message and then marking it as "unread" so it pops up at the top of the inbox later could also count as "handling it". In these cases, what is being "handled" is the predictable forgetfulness rather than the task itself. The task, if it's not forgotten, can be dealt with at a more opportune time.

Writing Everything Down

(Organization/Adaptation Strategy)

Whether it is because of a specific memory weakness or just because they have too much on their plate, writing everything down is the strategy being used by everyone whose desk, house, and computer are covered with sticky notes and reminders. When it comes to helping students with ADHD not forget things, externalizing information usually held in the memory can be extraordinarily helpful (Barkley R. A., 2021, p. 98).¹

As mentioned above, it is often best to keep organizational systems as simple as possible because people with ADHD often struggle with losing “things necessary for tasks or activities” (American Psychiatric Association, 2013). It is not uncommon for someone with ADHD to be surrounded by a self-created web of to-do lists, calendars, notebooks, and folders, and then lose track of these very tools that were supposed to help keep them organized.

This is why, for someone with ADHD, having a place to write everything down that is easy to access, hard to lose, and portable is paramount. Some people keep small notebooks in their pockets, some keep a running note open on their phone, and some text/email themselves so they can look at something later.

Some people with ADHD have never met a piece of paper they couldn't lose. For those people, digital versions of calendars and task lists are best because they provide backups across several platforms, helping avoid the problem of forgetting or losing paper.

Others like to have a “back-up” for their main memory externalization tool in the form of a large wall calendar around their house or near their workspace. Keeping these calendars up to date and in sync with online tools requires more upkeep, but it does solve the “out of sight, out of mind” problem some people have when they close their app or leave their planner in their backpack. Writing info down isn't very useful if one never looks at it.²

These external memory tools are not just for deadlines. They can also be used for things a person said they would do (“I will share with you on that file when I get home”), or for random thoughts about something they need to do later (“I need to double-space the assignment before I hand it in”). If one has memory issues, thoughts and commitments that aren't written down immediately, even with the best of intentions, may be quickly forgotten.

1. Cue a parade of smiling Learning Specialists and waving atop floats made of to-do lists, calendars, and notebooks.
2. Your ever-vigilant author once met a student who said they had their giant whiteboard calendar taped to the back of their bathroom door, across from the toilet. They said that way, they were sure to look at it every day.

Memory Support for Math

(Organization/Adaptation Strategies)

When measured with numerical stimuli, such as in digital span recall tests, working memory deficits appear more pronounced in people with ADHD (Barkley, Murphy, & Fischer, 2008, p. 432). Recent work on math performance among children with ADHD suggests “that math difficulties in children with ADHD are largely associated with neurocognitive factors such as working memory” (Gaye et al., 2025, p. 259). We can assume that in the post-secondary environment, adults with ADHD are similarly impacted by working memory weaknesses in their math classes.

There hasn’t been much research specifically on the kinds of math errors students with ADHD tend to make. Looking at the broader category of “learning disabilities,” a study of middle schoolers found that students with learning disabilities didn’t make significantly more computational errors than those without. However, they did make significantly more process errors related to number selection, operation selection, inclusion of irrelevant information, and “random slips attributed to a lack of self- monitoring” (Kingsdorf & Krawec, 2014, p. 71).

Many of these process errors result from a phenomenon of working memory called interference control. This kind of error is when a person is trying to hold information in their working memory, and it gets replaced by other information they see or hear, or information previously held in working memory (Barkley, Murphy, & Fischer, 2008, p. 172).

For a student in a math class, interference control errors related to working memory might look like: copying down the wrong numbers or signs from the question, doing a calculation correctly in one’s head but writing down a number from a previous step, typing the wrong numbers into a calculator, knowing the correct operation but using whichever was used most recently, and including information they know is irrelevant because they happened to look at it when they were writing down something else.

LSs can encourage math students to incorporate strategies into their workflow to help minimize reliance on working memory (by externalizing that information), and to double-check for working memory-related errors when they do occur. Examples of such strategies are:

- Double-checking numbers any time they are transcribed from one source to another (i.e., copying a question from a whiteboard or test to a piece of scrap paper to work through the calculations).
- Writing down each step in the question and each calculation, even if a student could easily do parts of it in their head.
- Trying to write neatly and keep questions organized.¹
- Doing calculations on a calculator (instead of in their head) if a calculator is allowed.
- Double-checking all calculations, both those in their head and those done on a calculator, to make sure they haven’t mixed up any digits or operations.
- Checking final answers against the questions to make sure the results are reasonable and answer the question asked.

Though essential for students with ADHD working on math, these strategies are little more than the old chestnuts our elementary teachers repeated ad nauseam: slow down, show your work, keep things neat, and check your answers when you are finished. Maybe they knew what they were talking about.²

1. See the impact of handwriting issues in [Specific Learning Disorders](#).

2. Sorry, Mrs. Bergveld.

Memory on Tests

(Adaptation/External Strategies)

Beyond having difficulty holding deadlines and commitments in one's head, people with ADHD can have issues with the retention of information over time (Barkley, Murphy, & Fischer, 2008, pp. 432-3). In testing environments, these memory issues are “more evident in free recall and were improved somewhat by cueing of the likely response category” (Barkley, Murphy, & Fischer, 2008, p. 432). Practically, this could explain why some students with ADHD find they do better on multiple-choice or matching questions (cued recall) than they do on short-answer, long-answer, and case-study analysis questions (free recall).

When working with a student with ADHD, an LS will want to stress the importance of understanding the format of an upcoming test; specifically, whether it will contain short- or long-answer questions or be mostly multiple-choice. If the student will be facing some short/long answer questions, an LS may want to recommend that they spend extra time practicing free recall questions.

As is standard protocol for an LS, supporting a student who needs to study for open-ended tests often involves helping them learn to generate practice questions using resources such as course outlines, instructional plans, lists of key learnings, or syllabi. If the student isn't good at generating these kinds of questions on their own, or if the faculty-provided material is lacking, there are some AI question generators, such as [AI Tutor Pro | Contact North | Contact Nord](#) (AI Tutor Pro, 2025), which might be helpful. Sites like these allow students to upload some of their content or course outcomes and specify that they want the program to generate short-answer questions. As with all emerging AI tech, one has to be flexible with these sites. Sometimes they may falsely tell students their answer is incorrect because the site was looking for very specific wording. It is up to the student to check their answer and see if it was more or less the same as the one deemed correct by our future AI overlords.

PART VII

STRATEGIES: FOCUSING IN CLASS

Focusing in Class

“Um, can you repeat the question?”

If someone knows nothing else about ADHD, they know that people with it have a hard time focusing at school. Focus, however, is an umbrella that covers many situations.

Barkley, in his attempt at a “unified theory” of ADHD, talks about focus, executive functioning, and self-regulation as dependent “on inhibition for their efficient execution” (Barkley, R. A., 1997, p. 68). A certain amount of behavioural inhibition is required to delay one’s reaction to a stimulus long enough to allow for an effectively regulated response (Barkley, R. A., 1997, p. 67). A person with inhibition-control weaknesses can’t help but react, on a cognitive level, to novel stimuli. These reactions can distract from what one was doing, at least temporarily.

In a classroom, the distracting stimuli are often environmental (i.e., people talking, a strange noise, or something happening out the window). Distracting stimuli aren’t always external, however. A person’s thoughts can be just as distracting. A student with ADHD attempting to work while wearing earplugs in an empty room could be just as distracted as one struggling to work in a loud coffee shop.¹

1. For more information, see [Mind Wandering](#).

Focusing in all Kinds of Classes

(Adaptation/External Strategies)

The common strategies LSs suggest to help all students stay focused also apply to students with ADHD – they might just need to be more tightly tailored. Some examples:

Online Classes (Synchronous or Asynchronous)

- Make sure to remove as many environmental distractions as possible. This could look like:
 - Closing all other computer windows or using an app blocker for the duration of the class.
 - Silencing their phone (or turning it off) and putting it in another room or giving it to a roommate/family member to hold until class is finished.
 - Finding a distraction-free place to watch the lecture (e.g. a different room in the house, or a library study room).
- Using social pressure to stay on task by leaving their camera on in an online class, even if others don't. This way, the instructor and everyone else will be able to see if they are looking at their phone or trying to play video games.

In-Person Classes

- Trying to take analog notes with a pen and notebook, and keeping their laptop and phone in their bag unless needed.¹
- Sitting in the front row if they need to use their computer. The social pressure of everyone behind them being able to see what they are doing on their screen can help keep them on task.

All Classes

- Making listening as active as possible by asking and answering questions in class. (Even if they don't always get the answers right).
- Looking at assignments as soon as they are given out, and asking clarifying until the student is crystal clear on what they have to do.
- Taking notes even if they think they don't need to. Active note-taking has long been shown to be beneficial for attention, memory, and academic performance (Voyer, Ronis, & Byers, 2022), and it is even more beneficial for students with ADHD (Shimko & James, 2025).²

1. See [Specific Learning Disorders](#) for more information on note-taking.

2. This can be tricky for some people with ADHD, as rates of learning disabilities (dyslexia, dysgraphia, visual motor integration issues, etc). are higher in those with ADHD than in the general community (Barkley, Murphy, & Fischer, 2008, p. 246). See the section on [Specific Learning Disorders](#) for more on those.

- Recording lectures for future reference/to catch up on missed notes. If a person has some of the other learning disabilities that tend to be comorbid with ADHD, the cognitive effort required to take notes could undermine their ability to focus. If a student in that situation is struggling to take notes, one solution is to encourage them to find ways to minimize their note-taking in favour of paying attention. Recording/transcribing software is great for this.

Exercise and Focus

(Adaptation Strategy)

People with ADHD (and parents of children with ADHD) have been using physical activity (PA) to “burn off some energy,” or “clear their head,” long before there was research to support its usefulness as a tool to help with attention. A recent review of the research on ADHD and physical activity found, “Regular PA improves executive functions, attention, inhibitory control, and cognitive flexibility in ADHD. Aerobic exercise enhances sustained attention, high-intensity training improves impulse control, and coordinative activities boost cognitive flexibility.” (Martín-Rodríguez, Herrero-Roldán, & Clemente-Suárez, 2025, p. 338). Exercise has also been shown to improve emotional regulation (Ratey, 2008).

For people with ADHD, exercising before a particularly boring lecture or finding ways to exercise throughout the day can be extremely helpful (Barkley, 2021, p. 206). The exercise doesn’t need to be elaborate or even fun, as long as it gets the heart pumping.¹

As LSs, we can help our students find physical activities that fit their needs, environment, and time constraints. Exercise can even be secreted into classes if one is crafty about it. For example, a scheduled break in a particularly boring lecture could be a time to find some stairs and do a few laps, or, instead of using a nearby washroom during a break, one could try using one farther away, requiring a rush to get there and back in time.

1. While working as a middle school teacher, your overzealous author, after reading *Spark: The revolutionary new science of exercise and the brain* (Ratey, 2008), did an experiment with a particularly squirrely 7th-grade class. After taking attendance, your hubristic author and their co-teacher made the students run up and down the two-story staircase in front of the school 5 times before heading back to class. After running, the student’s ability to focus and get work done jumped dramatically. Unfortunately, the practice was short-lived due to an untenable volume (at an untenable volume) of whining and complaining.

Fidgets and Other Sensory Tools

(External Strategy)

Fidget toys and sensory tools are plentiful, popular, and generally cheap. The tantalizing idea is that by occupying the gross or fine motor muscle groups that aren't needed for learning, they can provide additional sensory input, thereby relieving restlessness and improving focus/attention. Examples are fidget spinners or cubes for fine motor; wobble stools or stability balls for gross motor; or textured objects like stickers or Velcro pads for sensory input.

Fidget toys and sensory tools are a big market, despite a paucity of research on their efficacy. The research that does exist tends to focus on whole-class interventions for children, reports inconsistent effect sizes, and has small sample sizes (Schoenen et al., 2025).¹

A 2025 meta-study looking at the state of fidget toy research drew a few conclusions:

1. “The benefits of these devices appear to be negligible” (Schoenen et al., 2025, p. 324).
2. The best chance for fidgets to be useful for in-class restlessness and focus is when their deployment is highly individualized. The fidget should be selected with the person to fit them in a particular environment, at a particular time. Even then, people tend to become habituated to the fidgets they are using, and fidgets “may lose any positive or negative effect quickly” (Schoenen et al., 2025, p. 323).
3. Fidgets may be even less useful for adults, since by the time they reach higher education, older students have usually “developed different coping strategies making a fidget less necessary” (Schoenen et al., 2025, p. 317).

Where does this leave us as Learning Specialists when it comes to fidgets or sensory tools? If someone thinks that additional sensory stimulation during class would help them focus, our best strategy, instead of just recommending whatever plastic toy is in fashion, is probably to have students reflect on the coping strategies they already use and find ways to deploy them more mindfully. The goal is to find an action they can engage in without requiring their attention.²

Having the fidget/sensory input be something one doesn't have to pay attention to rules out most doodling. Even if it starts out mindless, doodling has the potential to become an attention stealer.³ “Fidgets” and fidgeting behaviour need to be monitored to make sure they are tools and not distracting to themselves or others.

1. The rare study that considered neurodiverse students had a grand total of 4 participants (Kercood & Banda, 2012).
2. For more problematic examples of seeking sensory stimulation, see the section on [Non Suicidal Self Injury](#).
3. Your sensitive and stimulating author once worked with a student who said they doodled during lectures to pay attention. The student was quite excited to show off the sketch of Toothless from the movie *How to Train Your Dragon* that they had drawn earlier that day. The drawing was quite good. When asked what the lecture was about, the student sheepishly admitted that they only remembered the beginning; as the drawing became more engrossing, they paid less and less attention.

PART VIII

HIDDEN SYMPTOMS OF ADHD

Hidden Symptoms: Further Complications

The image many of us have in our heads of someone with ADHD is the classic adolescent boy with no impulse control who is bouncing off the woodwork. Picture Bart Simpson after a few cups of espresso. While sometimes this is accurate (it's now almost pro forma to test energetic young boys who disrupt class for ADHD), the Caffeinated Bart is a shallow caricature of ADHD that belies the breadth and depth of possible ADHD symptoms and symptom presentations.

The less visible symptoms/effects of ADHD in adults are legion and manifest differently for each person. To complicate things further, an area of weakness for one person might be a relative strength for another. ADHD is a “syndrome of paradoxes” after all (Hallowell & Ratey, 2010, p. 12).

What follows are some common symptoms/manifestations of ADHD that may fall under the radar. For some of the following topics, the research is new or is just being started. For other topics, “scientific” research might not exist. Some of these topics are included here because they are part of the current ADHD zeitgeist. Someone may experience a particular behaviour/effect, whether or not it has been quantified or “legitimized.” On the other side of that coin, echoing through social media while getting many likes and reposts also doesn't constitute proof that a symptom or behaviour is related to ADHD.

In the sections below, we still try to work from the substantiated to the less so.

Specific Learning Disorders

Students with ADHD are much more likely to have specific reading and writing learning disorders (Willcutt & Pennington, 2000; Mayes, Frye, Breaux, & Calhoun, 2018). What used to be called dyslexia, dysgraphia, and dyscalculia are, in the DSM-5, now referred to as specific learning disorders (SLDs)¹ in the areas of reading, written expression, and mathematics.² Although the high comorbidity of ADHD and reading and writing SLDs has mostly been studied in children, reading and writing disorders, like ADHD, tend to persist into adulthood (Döpfner et al., 2015; Bruck, 1990; Bruck, 1992).

SLD in Reading

Research that specializes in confirming the obvious has found that children with reading disabilities are less academically successful in school than those without. The same negative effect applies to students with ADHD (Willcutt et al., 2007). When comorbid, these effects amplify each other, and people with both ADHD and an SLD in reading do worse than people who just have one or the other (Willcutt et al., 2007).

In non-obvious findings, a study of students who attended and graduated from Yale found that students with dyslexia were just as successful over 4 years as their non-dyslexic peers. These students continued to be just as successful in their jobs after college (Shaywitz, Holahan, Kenney, & Shaywitz, 2020). Participants of the study who had dyslexia mentioned having to work harder than their peers and needing to keep trying new strategies to meet the changing demands of school (Shaywitz, Holahan, Kenney, & Shaywitz, 2020). As optimistic as that sounds, the study didn't mention that to develop the skills needed to be admitted to an elite university, and to afford the incredibly high tuition, a Yale student with a reading disorder would probably have had access to a level of resources and support unavailable to the average student.

A post-secondary student with an SLD in the area of reading is probably well aware of the glut of technology available to help. If they are not, it should be one of the first things an LS recommends.

Software like Read and Write and the read-aloud functions built into many programs, apps, and devices have changed the landscape for students with reading issues. They are amazing – when they work. When they don't work, they are an infuriating time suck. Sometimes a particular read-aloud software doesn't work with a certain document/PDF, or it's erratic with the school's learning management system, or it is stymied by an inaccessible textbook or website. For these reasons, it is best to refer a student to the Assistive Technology department (if the school has one). They are the experts and can help a student test different documents, troubleshoot problems, and ensure the tool is helpful rather than a hindrance.

A low-tech solution that an LS can recommend is to finesse the readings by only reading what is necessary. To help determine what readings are necessary, an LS can ask such prompting questions as:

- Do the lectures cover the same content as the readings? Or is there some material that wasn't covered at all? – If so, then maybe they only need to pay attention to the parts of the readings that weren't covered in class.

1. A note on vocabulary: Until relatively recently, “specific learning disorders” were referred to as “specific learning disabilities.” Officially, “disorder” is the preferred terminology. “Disability” is still often used in legal and social contexts. For a deep dive into the differences and definitions of diagnostic terminology, see Srivastava's thorough rundown (Srivastava, 2022).

2. See [Memory Support for Math](#) for more information.

- Do the readings seem to just give extra detail and examples of the material already covered in class? – If this is the case, they may be able to skim to make sure there is nothing new, and then only spend time on the sections where they need more clarification.
- Judging by your previous tests and quizzes, is the content coming more from either the readings or from class? – If the quiz and test content are only coming from the lectures, then maybe the instructor isn't using the assigned readings very heavily.

The message to get across is not that students should skip their readings; it's that they need to use the information they have to read as efficiently as possible.

SLD in Writing

The handwriting of students with ADHD tends to be slower and less legible than that of students without ADHD (Graham, Fishman, Reid, & Hebert, 2016). Students with ADHD are also much more likely to have specific writing disorders (Mayes, Frye, Breaux, & Calhoun, 2018).

Formerly known as dysgraphia, the new official term for these writing disorders is “specific learning disability with impairment in written expression” (American Psychiatric Association, 2013). The term “dysgraphia” still comes up; however, as researchers try to get to the bottom of SLD, they have been distilling “dysgraphia” into its various component “graphias”

Motor or Peripheral Dysgraphia is sometimes used to denote a condition in which the individual may have illegible handwriting due to fine-motor or visual-perception issues, but whose oral spelling is unaffected (Chung, Patel, & Nizami, 2020).

Spatial Dysgraphia was proposed as a variant in which the impairment affects spatial perception (e.g., letter spacing and drawing) but leaves oral spelling unaffected (Chung, Patel, & Nizami, 2020).

Dysorthography (AKA: Linguistic Dysgraphia, AKA: Dyslexic Dysgraphia), which places less emphasis on motor skills and views the disorder as a failure of communication between phonologic and orthographic memory (Chung, Patel, & Nizami, 2020).

Regardless of how it may be categorized and labelled, a post-secondary student with an SLD in the area of writing could struggle with taking notes by hand, copying information, reading their own writing, spelling, written grammar and/or organizing and writing down their thoughts (Chung, Patel, & Nizami, 2020). Add to this the attentional issues of someone with comorbid ADHD, and taking useful notes in a lecture becomes daunting at best, and a counterproductive waste of time at worst.

Active note-taking in class has been shown to be beneficial for attention, memory, and academic performance (Voyer, Ronis, & Byers, 2022), especially for students with ADHD (Shimko & James, 2025). Fortunately, typing is just as effective as handwriting when it comes to taking notes in a lecture (Shimko & James, 2025). Typing may be ideal, but “the optimal modality [for students with ADHD] may depend on individual transcription abilities” (Shimko & James, 2025, p. 541). LSs can help students find their ideal notetaking workflow by introducing notetaking strategies and technologies for them to audition. Some examples would be:

- **Printing slides in advance:** Having the content already in front of them means the student can write or annotate the slides directly and only needs to write down additional information they deem important.
- **Importing the slides to a note-taking software:** In a digital version of printing the strategy above, programs like OneNote will let students make notes/annotate directly on the slide via typing or using a stylus.
- **Recording the audio of lectures:** If a student knows there will be a recording to catch anything they miss, they can focus on comprehending the lecture's content rather than trying to copy down every detail. There are many programs or apps that can do these recordings. Or one could just use a phone's voice note function.³

- **Using speech-to-text programs outside of class:** These take some getting used to but can be very helpful with taking notes on readings at home.
- **Learning to type more quickly:** This is obviously not a quick fix, but there are lots of free online programs to help anyone who wants to learn to type faster.

3. As of 2026, a neat piece of software called Genio does a good job of this. It can record the lecture, make a transcript, link the lecture to the slides, and link the student's typed notes to what was being said at the time. It is a paid app, but at some schools, Accessible Learning or Assistive Tech departments may have educational licences available to students who qualify for accommodations. Individuals can also pay to use it.

Sleep Issues

Across a plethora of studies, adults with ADHD reported a high level of sleep issues and daytime sleepiness (Wajszilber, Santiseban, & Gruber, 2018). Insomnia Disorder is estimated to affect up to 44% of people with ADHD (Fadeuilhe et al., 2021), with Sleep Phase Disorder (characterized by delayed circadian rhythm) estimated to affect up to 78% (Bijlenga, Vollebregt, Kooij, & Arns, 2019).

When comparing adults with ADHD who do and don't have sleep disorders, the news isn't rosy. Those with sleep disorders report an increase in the number and intensity of ADHD symptoms. They also report higher rates of inattention and more executive functioning and information processing difficulties (Wajszilber, Santiseban, & Gruber, 2018). As one group of researchers put it, adult ADHD patients with a sleep disorder "have a worse clinical presentation due to a higher ADHD severity, more comorbidities, and worse quality of life" (Fadeuilhe et al., 2021, p. 10).

Since sleep problems are so endemic with people with ADHD, some researchers have even gone so far as to propose a new subtype named ADHD SOM (from the Latin *somnus*, meaning sleep), where part of a person's ADHD symptoms are a result of chronic sleep issues. Shortening a new category, they think that when evaluating someone for ADHD, clinicians should also investigate potential sleep disorders (Bijlenga, Vollebregt, Kooij, & Arns, 2019).

In terms of an LS's interaction with a student with ADHD and sleep issues, offering time management strategies to help the student avoid sleep deprivation from procrastination or poor planning is probably our best bet.

"Good sleep hygiene" is the unsupported advice for sleep issues given by an ocean of websites (and echoed by AI). Sleep hygiene is a nebulous term that isn't well-defined in the research, but usually refers to strategies like limiting caffeine, alcohol, and smoking; napping; screen time; and establishing wind-down routines and ways to manage stress (De Pasquale et al., 2024). Evidence supporting good "sleep hygiene" as an effective method for treating insomnia appears to be anecdotal rather than evidence-based (Dietrich, Francis-Jimenez, Knibbs, Umali, & Truglio-Londrigan, 2016; Riemann et al., 2023).

Evidence-based treatments for a student with chronic sleep issues would necessitate consulting their doctor (for a pharmacological treatment) or a therapist (for Cognitive Behavioural Therapy focused on insomnia) (Chung et al., 2018; Riemann et al., 2023). In a rare ray of light peeking through the blackout bedroom curtains, it looks that treating one's ADHD (pharmacologically or non-pharmacologically) for more than two years can reduce the likelihood of comorbid sleep disorders (Fadeuilhe et al., 2021).

Non Suicidal Self Injury

For people with ADHD, a somewhat common, less optimal way of fidgeting/seeking sensory stimulation is what is termed NSSI, or non suicidal self injury. These can include behaviours such as cutting, scratching, burning, or preventing wounds from healing. The versions that might be most visible in a school setting include behaviours like picking at skin on the hands or head, twirling hair until it pulls out, or scratching until the skin breaks.

In the general population, 13-17% of adolescents and young adults, and 6% of adults have engaged in NSSI (Swannell, Martin, Page, Hasking, & St John, 2014). A study looking at post-secondary students across 6 countries (including Canada) found that 20% had engaged in NSSI, and about 70% of those hadn't sought professional help (Lindquist et al., 2025). Among adults with ADHD, 25% have engaged in NSSI, with the prevalence among adolescents with ADHD being slightly higher at 28% (Smaniotto et al., 2026).

NSSI behaviour is often associated with, or seen as a symptom of, other mental health issues. Beyond having ADHD, other risk factors for NSSI include prior self-harm, hopelessness, family tension or lack of support, adverse childhood experiences, bullying, parental depression, etc. Protective factors for NSSI include the ability and willingness to talk to someone about their NSSI, connections to parents, friends, attachment figures, feeling safe at school, and higher grades.

An unexpected finding of a review of why people engage in NSSI was that many saw it as an adaptive behaviour rather than just being a reaction to something negative (Edmondson & House, 2016). In this review, more than 20% of participants listed sensation seeking (i.e. sensory self-regulation) as one of the "beneficial" aspects of engaging in NSSI (Edmondson & House, 2016). For someone with attention issues (i.e., ADHD), sensory-seeking behaviours (including NSSI) can be performed without much present awareness.

If an LS notices behaviours like these during a meeting with a student with ADHD, or if a student discloses NSSI behaviour or that they are struggling with other mental health issues, the best reaction is probably a caring conversation and a referral to other on-campus medical or mental health services, if the student consents. LSs aren't therapists, and there are others on campus who are actually qualified to conduct a formal risk assessment.

For an LS, meeting with a student who is in the midst of a mental health crisis is going to happen sooner or later. It is better to be prepared rather than trying to wing it. There are a lot of resources, and often on-campus trainings, on how to navigate situations when either a student discloses NSSI or suicidal thoughts, or when the LS suspects a student might be thinking about suicide. The [Center for Innovation in Campus Mental Health](#) has resources and training information for post-secondary staff and faculty. Another helpful training, frequently offered online, is safeTALK, which is a program designed to teach non-therapists to recognize and respond to the signs of suicide.

Rejection Sensitivity

“Oversensitivity to criticism,” “rejection sensitivity,” and, more recently, “rejection sensitivity dysphoria” are terms used to describe difficulty regulating emotional responses to real or perceived instances of criticism or rejection (Downey & Feldman, 1996; Atlas, 1994). As the terms seem interchangeable (depending on who is doing the research), we will use the term Rejection Sensitivity (RS) here.

The research into RS and ADHD all seems to be relatively recent. This sensitivity seems to come from issues with emotional regulation, which some include as one of the executive functions with which people with ADHD tend to struggle (Barkley, Murphy, & Fischer, 2008, p. 401).

While the research on RS and ADHD isn’t robust, it is consistent. Whether from experiences relayed in clinical case studies, qualitative studies interviewing small groups of students, or using self-reported measures, the data sprouting from this green branch of research does tend to show a correlation between RS and having ADHD, or, in the absence of an official diagnosis, between RS and an increased number of ADHD symptoms (Beaton, Sirois, & Milne, 2020; Beaton, Sirois, & Milne, 2022; Dodson, Modestino, Ceritoğlu, & Zayed, 2024; Sandland, 2025; Rowney-Smith, Sutton, Quadt, & Eccles, 2026).

In the academic setting, rejection/criticism sensitivity can be triggered by any number of events. It could be someone getting a lower grade than expected or receiving critical feedback from a teacher or group member. Or it could be from perceived criticism, such as a student believing, during a class discussion, that their teacher or classmates are silently judging them, or thinks they said something wrong.

The results of this RS are as numerous as the potential triggers. People report RS producing feelings of embarrassment, anger, shame, anxiety, and despair (Rowney-Smith, Sutton, Quadt, & Eccles, 2026), with some even identifying physical reactions such as pain, exhaustion, and nausea (Sandland, 2025). People with RS also tend to be less self-compassionate (Beaton, Sirois, & Milne, 2020) have a lower sense of self-worth (Beaton, Sirois, & Milne, 2022), and are more likely to adopt avoidance behaviours or withdraw socially.¹ (Müller, Mellor, & Pikó, 2024; Rowney-Smith, Sutton, Quadt, & Eccles, 2026).

Treating the RS is a long process that falls more into the realm of a therapist or counsellor rather than that of an LS. However, as LSs, we can support people with RS by offering encouragement, advising on navigating sticky group or classroom situations, and helping reframe critique feedback on assignments as being about the work, not the person.

1. Examples of avoidance behaviours would be: not handing in assignments, not participating in class discussions, or opting not to work in groups

Mind Wandering

Despite it being prevalent among people with ADHD (Lanier, Noyes, & Biederman, 2021), mind wandering isn't one of the symptoms listed as diagnostic criteria in the DSM-5. Mind wandering insinuates itself into the diagnostic manual as an example/point of clarification for two inattentive symptoms: "c) Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction)," and "h) Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts)" (American Psychiatric Association, 2013).

Daydreaming, or mind wandering, for a person with ADHD may come from previously mentioned issues with inhibition control. Just as they struggle on a cognitive level to inhibit their reactions to sights and sounds that enter their field of vision, a person with ADHD may also be unable to inhibit their reaction to a distracting thought or emotion (Barkley, R. A., 1997). This could be the case for our ADHD-I student, who looks like they are on task and paying attention in class, but has no idea what is going on when asked a question.

For most people, mind wandering and daydreaming are harmless and enjoyable ways to combat boredom. For people with ADHD, though it may be a boredom antidote, mind wandering can also make tasks take much longer than expected.

A more extreme form of daydreaming, called Maladaptive Daydreaming (MD), is currently being studied and has been proposed as a disorder in the next version of the DSM. MD is being defined as when "an individual is excessively absorbed in an internal fantasy world in a manner that causes clinically significant distress or impairment in social, occupational, or other important areas of functioning" (Somer, Soffer-Dudek, & Ross, 2017, p. 525). One team of researchers found that in a group of people evaluated for MD using their proposed diagnostic criteria, 20% of those who "qualified" for MD also had ADHD. The MD subgroup that had ADHD also presented more issues with depression, loneliness, and self-esteem (Theodor-Katz, Somer, Hesse, & Soffer-Dudek, 2022). Another study found that for people who met the proposed MD criteria, the most common comorbid disorder was ADHD (Somer, Soffer-Dudek, & Ross, 2017).

Not everyone with ADHD who daydreams has MD, but anyone who notices that daydreaming is affecting their education may benefit from an LS's help in finding tools and strategies to bring themselves back into the moment.¹ If the daydreaming issues are severe and are affecting a student both in school and in other aspects of their life (i.e. if their daydreaming is drifting into MD territory), a referral to on-campus counselling/therapy services would be beneficial.

"Bring themselves back to the moment," you say. "Do you think people with ADHD should practice some sort of mindfulness or meditation?" Well, dear reader... that's a complicated question. In brief, there has been a swarm of studies in the last decade trying to show that meditation and mindfulness are great for people with ADHD. Unfortunately, much of this research has been problematic. The studies often involve small sample sizes, questionable experimental designs, clear conflicts of interest for the researchers, or mixed results. Some individuals with ADHD might have great results with mindfulness practices and swear by it. Others find all that sitting still difficult and are frustrated when they are never able to "quiet their mind." As one meta study looking at mindfulness-based interventions (MBIs) for adults with ADHD put it, "MBIs may be effective in improving core ADHD symptoms and overall functioning in adults with ADHD. However, their effects on emotional well-being and mindfulness skills remain inconclusive" (Kim & Jung, 2025, p. 1). "May be effective" and "remain inconclusive" are the boldest and most certain claims that those looking critically at the research seem willing to make.

1. See previous sections on [Focusing in Class](#) and [Time Management and Organization](#) for some of these strategies.

Hyperfocus

Despite the study of this phenomenon being in its infancy, hyperfocus, as an ADHD symptom, is a darling of social media. Some research has found an increase in “hyperfocus” behaviour as ADHD symptoms increase (Hupfeld, 2019). However, this research is limited.

One reason for the paucity of research is that in the psychological literature, the term “hyperfocus” doesn’t have a standardized definition or an agreed-upon method of measurement. Colloquially, hyperfocus is seen as the complete absorption in a task to the point where a person ignores or “tunes out” everything else (Ashinoff, 2021).

But wait, you say, I thought the second “D” stood for “Deficit.” How can a person hyperfocus when they have an “attention deficit”?

Well, it has been argued by some that the word “deficit” in ADHD is misleading. This idea posits that the problem isn’t that a person with ADHD can’t pay attention; it’s that they can’t regulate their attention effectively (Ginapp et al., 2023). Someone with difficulty regulating attention might struggle to pay attention in a boring class, just as much as they may struggle to stop paying attention to a YouTube channel they are particularly interested in.

The inability to regulate attention is a double-edged sword. In school, if a student is interested in a particular task or assignment, it may translate to intense focus and produce very thorough work. On the flip side, it could mean they spend an inordinate amount of time working on a preferred assignment while ignoring all other deadlines.

An LS working with a student with ADHD may see hyperfocus/attention regulation issues breach the surface in Time Management Bay, on the coast of Procrastination Island. The classic example is a student missing a meeting or a deadline because they were playing video games/watching videos and lost track of time. The first step in assisting a student who realizes hyperfocus may be a problem is to help them identify ways they could break that focus and move on to something else. Ideas for this could be any one of the time management or procrastination suggestions mentioned earlier (alarms, digital reminders, etc.).

The next step, once they have managed to wedge a foot in the door and see beyond their current fixation, would be to have them imagine the potential consequences of not regulating their attention. An LS could encourage the student to ask themselves questions like, “Is this what I should be doing right now?” And, “if I keep doing [insert subject of hyperfocus here] instead of working on X, what will the consequences be?”¹

1. An LS can also help a student use hyperfocus for good. See the section on [Harnessing Interest to Spur Action](#) for more information on this.

Decision Paralysis

Decision Paralysis, nee Decision Avoidance (Anderson, 2003), is another current social media ADHD buzzword. The narrative is that people with ADHD can face such extreme difficulty in making decisions that they often can't make a decision at all – even when the decisions are small and inconsequential. As of 2026, there is little research out there specifically on ADHD and decision paralysis.¹

There has been some work on ADHD decision-making (DM) in general. A daring claim made in a meta-study looking at people with ADHD and “risky” decision making, decisions made in reinforcement learning tasks, and decisions made between intermediate and delayed rewards was: “The results support the existence of DM deficits in adults with ADHD, which are of similar magnitude as attention deficits” (Mowinckel, Pedersen, Eilertsen, & Biele, 2015, p. 355).

Difficulty with decision-making can impact a student when choosing topics for a research paper, selecting group members, deciding which notes to take, and figuring out what to work on next, etc. It's not uncommon to find a student with ADHD a day or two away from a paper deadline, not yet having chosen a topic. This likely isn't laziness. They have probably done mountains of research or mapped out the pros and cons for each topic; they just haven't settled on the “best one.” The opposite may also be true. To avoid the stress that comes with decision-making, a person with ADHD might just make a snap decision without considering any of the consequences and then try to make that option work, for better or worse.

For some, “talking out” the decision-making process (i.e. externalizing their thinking) can be helpful. As LSs, we can facilitate this process by asking clarifying and probing questions to help them sort through their options. To help a nursing student choose a topic for their overdue research paper, your verbose author once found themselves asking questions like, “Do you want to have a topic that focuses more on community health or hospital care? If you choose community health, are there particular areas that interest you, such as public policy, public awareness campaigns, or public medicine? Are there public awareness campaigns you think were particularly effective or ineffective? Is there enough info out there for topic A, or are you really going to have to dig to find stuff? Since you need to finish as soon as possible, which topic do you think would take you the least amount of time?”

If you are helping a student verbally process a decision, make sure to give them plenty of time to process their thoughts. Asking too many questions too fast can be flustering, as people with ADHD can have “significant reductions in processing speed.”² (Anker, Ogrim, & Heir, 2022, p. 224). If you have asked a question and the student has gone quiet, and you are not sure if they are still thinking or stalled out, you could ask something like, “What are you thinking about for this one?” If someone is having a hard time deciding (especially if you suspect a processing delay), it is important to avoid introducing more options or complicating the ones they already have. Doing so may have the unintended consequence of restarting the decision-making process from the beginning.

1. The sole article seems to be the summary of a conference talk published in *European Psychiatry* 2025 (Oroian, Nechita, & Szalontay, 2025). Though the study sounds interesting, the full paper doesn't appear to have been published at this time.
2. A delay in processing speed (taking in information, processing it, and formulating a response) could also be hindering decision making

Overcommitting

Overcommitting can be a common issue for people with ADHD (Hallowell & Ratey, 2010, p. 318). This overcommitting may look like a person with ADHD trying to be helpful and agreeing to take on an extra section of a project, volunteering to pick someone up at the airport, or promising to finish and send a document when they get home, without first considering whether they have the time to do so.

The roots of this kind of behaviour are myriad. Part of the issue of overcommitting stems from the omnipresent executive functioning challenges with planning, time estimation, time reproduction, and time management that come with ADHD (Mette, 2023). Another theory is that overcommitting may have something to do with the propensity of people with ADHD for novelty-seeking behaviour (Donfrancesco et al., 2015), and dopamine levels in the brain (Hallowell & Ratey, 2010, p. 299) Unconsciously trying to scratch that cognitive chemical itch, the drive for novelty and excitement can result in a person with ADHD finding hundreds of little things each day to fill up their time.¹

For a student with ADHD, having a hard look at what actually “needs” to get done (re-evaluating priorities) and finding ways to accurately externalize and track time can help with overscheduling/overcommitting. Just booking time for all of those things can help make those obligations feel dealt with, reduce stress, and allow one to focus on more important tasks. During this winnowing process, it can be useful for a student with ADHD to consult someone outside the situation who can offer an unbiased perspective (viz., an LS).

Overcommitting/over-scheduling can even happen when a person with ADHD is supposed to be relaxing or taking it easy. For someone with ADHD, a day off from work can easily turn into a hectic eight hours spent running around trying to squeeze in every errand or to-do they can think of. It takes some people a while to realize that crashing at the end of the day due to physical and mental exhaustion isn't the same as relaxing. Having “difficulty unwinding and relaxing when you have the time to yourself” is one of the criteria on the ASRS screener for a reason!² (Kessler R. C. et al., 2005).

For someone who finds it difficult to relax or take a break, scheduling activities that help them relax and recharge can help avoid burnout. An important thing to remember, going back to the idea of [implementation intentions](#), is that it is usually more effective to schedule a specific relaxing activity at a specific time, as a generic “relax time” in one's calendar can all too easily fill up with “important” exhausting nonsense.

1. Like endlessly researching more and more topics for a guide about ADHD for LSs.
2. It's not uncommon to hear of a person with ADHD talk about using substances like alcohol and cannabis to help them relax and sleep. Unfortunately, this kind of use of substances can also lead to an exacerbation of ADHD symptoms (Goldstein, Shifrin, Katz, Iu, & Kofler, 2021).

Stalling Out on a Projects

It is common for people with ADHD to stall out towards the end of a project/assignment, or once finished a task, to struggle starting the next one (Hallowell & Ratey, 2010, p. 98). Starting a project might have been hard, but once underway, projects/assignments can provide both structure and stimulation to one's life. Finishing a project means those stabilizing benefits suddenly disappear. A counterproductive solution the ADHD brain sometimes generates to avoid the unmoored and off-kilter feeling that comes with starting something new is: just keep working on the project – forever.¹

Having a solid plan of what to work on next before finishing the first task can help (Hallowell & Ratey, 2010, p. 98). This might look like planning or starting the next project while the first one is still underway. Knowing what is coming next can make finishing the existing project feel like less of a loss, and it can help starting the next one seem less daunting. Using the procrastination strategy of starting on the smallest/least intimidating part of the next project can also be useful. Once a student gets started on something, their mood can quickly turn around, making the next project feel more surmountable and the current one less dear (Pychyl, 2013).

1. A guide for LSs on working with students with ADHD, for example.

PART IX

ADHD MEDICATIONS

ADHD Medications: Generally Safe and Effective

Medications to treat ADHD are generally safe and effective. Studies have shown that ADHD medication can “normalize” behaviour in 50-60% of people and result in substantial improvements in 20-30% of people (Barkley, R. A., 2021, p. 107). This doesn’t mean that the medication magically solves all the problems in a person’s life; “normalize” is a very subjective term after all. Taking the goal of reaching some arbitrary definition of “normal” off the table, medication usually has significant positive effects on executive functioning, working memory, and emotional regulation.

Taking ADHD medication is like wearing hearing aids. Having less-than-perfect hearing isn’t a personal failure; needing to wear hearing aids doesn’t change who a person is. Some people who might benefit from hearing aids get by just fine without them, but wearing a set can have a huge impact on how a person interacts with their environment. Since the world is not going to change to suit those with ADHD, people with ADHD can use medication to adapt to the world (Barkley, R. A., 2021, p. 105).

Whether or not to take medication is a personal decision that many wrestle with because of the stigma still associated with ADHD meds. Contrary to the beliefs of the pearl-clutching set, 50 years of research has shown that stimulant ADHD medications aren’t addictive, and they don’t act as a gateway drug to other addictions (McCabe et al., 2023).¹

Being diagnosed early and being treated with stimulant medications also seems to lower a person’s risk of developing common ADHD comorbidities such as anxiety and depression. In a study done over 10 years, researchers found that being diagnosed and treated with stimulants when a child/youth lowered the risk of being held back a grade in school, and tended to lower one’s risk for depressive, disruptive, and anxiety disorders as an adult.² (Biederman, Monuteaux, Spencer, Wilens, & Faraone, 2009)

1. It may actually be the opposite. See [Self-Medication](#) for more details.

2. Unfortunately, this study included only male subjects.

Classes of ADHD Medications

When starting to take ADHD medication, there is often a trial-and-error process as patient and doctor work together to find the right one at the right dosage.

Depending on the side effects, a student in the process of figuring out medication may struggle with time management and organization as much, or more, than they did without medication. If a student shares that they are in the midst of figuring out medication, the LS working with them should anticipate that the student might be frustrated by their inconsistency. One day, the medication may seem to be really effective, and the next day, they may wonder if somehow the medication is making their executive functioning worse.¹

In general, there are 3 classes of medications for ADHD: Stimulants, Non-Stimulants, and drugs for other conditions being used off-label to treat ADHD. Given that their effects and side effects may affect student learning, it can be helpful for an LS to be knowledgeable about these pharmacological treatments.

Stimulants

Stimulants are by far the most common treatment for ADHD. There are two broad categories: those based on Methylphenidate (your Ritalins and Concertas), and those based on Amphetamines (your Aderalls and Vyvances). Some people tend to respond better to one of the two classes of stimulants. Both groups have various timed-release formulas and various delivery methods (pill, patch, etc.).

Stimulants affect levels of neurotransmitters such as dopamine and norepinephrine, and improve signal processing in the brain (Nadeau, Littman, & Quinn, 2015, p. 282). When the correct medication and dosage are found, most people have improved symptoms (Wolraich et al., 2019).

Stimulant Side Effects and Complications:

For some, ADHD stimulant medications cause side effects or worsen existing conditions, even while helping with ADHD symptoms. Common side effects of stimulants are headaches, decreased appetite, stomach aches, sleep issues, irritability, jitteriness, and/or an increase in blood pressure (Barkley, R. A., 2021, p. 202). Often, these side effects are short-lived and decrease within the first months of treatment (Nadeau, Littman, & Quinn, 2015, p. 281). If symptoms persist (or are severe), the doctor might switch the drug or adjust the dosage.

If a person has other mental health conditions, such as anxiety, OCD, Bipolar Disorder, or Tourette's, stimulants may not be a doctor's first choice as they can sometimes exacerbate the symptoms of those disorders.² (Nadeau, Littman, & Quinn, 2015, p. 288). If this is the case, a doctor may try a different variety of stimulant or opt for a non-stimulant

1. Which may be the case if the medication is disrupting their sleep.
2. Some doctors are particularly hesitant to prescribe stimulants to patients with comorbid Bipolar Disorder, as there is a fear that these drugs may induce mania. The research around this is not clear-cut. Some studies report induced mania as an issue, some don't, and others find that interaction effects are highly influenced by age (Girard & Joobar, 2017). Because of a lack of clarity in the research and the potential risk involved, many doctors err on the side of caution and opt for non-stimulant treatments in these cases.

treatment. Sometimes, conditions like anxiety and depression actually improve when the underlying condition of ADHD is being treated.

ADHD stimulant medications are a controlled substance in Canada.³ Because of the controlled status, it can sometimes be tricky to get prescriptions filled in a hurry. Some pharmacies only allow certain employees to access stimulant medications, and if that person isn't there, the prescription isn't getting filled. Refilling prescriptions early can also be a no-go, as pharmacies keep track of how many pills were issued and how often they were to be taken. One can't refill the prescription unless the pharmacy calculates that a patient's supply is getting low.

Since caffeine is also a stimulant, some people become more sensitive to caffeine when taking ADHD stimulant medications (Barkley, R. A., 2021, p. 208). Stacking the two stimulants on top of each other can make some people feel jittery, restless, and like they have taken too high a dosage of the medication or are over-caffeinated. In these situations, caffeine can negate the positive effect of medication and make it nearly impossible to focus or get things done. On the other hand, some people don't notice this effect at all and are fine drinking caffeine as usual.⁴

Non-Stimulants

Non-stimulants are usually less effective and are seldom the first line of defence. (Newcorn, Krone, & Dittmann, 2022) If a person doesn't want to try a stimulant or if a stimulant was tried and has been found to be untenable for some reason, doctors may reach for non-stimulant medications. There are two broad classes of non-stimulant medications: noradrenergic reuptake inhibitors and alpha2-adrenergic agonists. (Newcorn, Krone, & Dittmann, 2022) Some examples are Strattera, Viloxazine, Clonidine, and Guanfacine. Some of the most common side effects are sleepiness, decreased appetite, and irritability. (Newcorn, Krone, & Dittmann, 2022; Nadeau, Littman, & Quinn, 2015, p. 284)

Off-Label Drugs

These are drugs that are approved for the treatment of other conditions, but people have found some success in using them to manage ADHD symptoms. Research showing if, and which off-label drugs are effective in treating ADHD, is scarce. Most of the research focuses on *how often* off-label drugs are being prescribed to treat ADHD, rather than on the efficacy of any particular medication.

Sometimes off-label drugs are used when the regular ADHD drugs interfere with other medications or health conditions. If a person is being treated for ADHD as well as another condition, a doctor may choose one medication over another for the second condition if one choice has the potential side effect of helping with ADHD. The most common off-label drugs that come up to treat ADHD are antidepressants like Wellbutrin (aka bupropion). (Newcorn, Krone, & Dittmann, 2022)

3. Other countries also have restrictions, so people who take these meds need to check carefully before they travel. As of 2006, for example, Japan allows travellers to enter the country with Concerta, but not Adderall. Adderall is illegal to possess in Japan, even with a valid prescription from one's home country.

4. For more information on caffeine, see the [Self Medication](#) section.

Doin' Drugs at School

Despite evidence of their effectiveness, it is not uncommon for college and university students with ADHD living on their own for the first time to stop taking their established ADHD medication (Quinn, 2001, p. 50). The reasons for this are myriad. Some simply forget to take a pill every day because no parent is around to remind them. For some, it's a way to assert their independence after being hounded to take their meds for years. And for others, it may be an experiment, after years of taking medication, to see how school goes without it.

Whatever the reason, attempting the increased demands of college/university without the benefits of medication they are used to, combined with the complications and stress of living on one's own for the first time, can leave abstaining students overwhelmed early in their first term (Quinn, 2001, p. 50). As LSs, we can't give medical advice, but we can remind students that whenever anyone is making medication changes, they should do so with their doctor's help.

Timing and Scheduling

Timing ADHD medications (especially stimulants) can be tricky for students as they will need to factor in their daily routines, their class schedules, and the efficacy window of their medication. The classic Ritalin from the 80s and 90s kicked in quickly, had a short active time, and sometimes a hard crash. Modern meds are preferable, as newer formulations tend to be timed-release with active times of 6-12 hours and a more gradual taper at the end of the day.¹

A student with later classes might take their medication later to ensure the effect lasts into the evening. The trade-off is that taking the medication later in the day could affect sleep by keeping them up at night. A student with morning classes might take their medication early to help them focus in class, only to find they have difficulty working in the evenings when the medicine wears off. Luckily, ADHD medications don't need to be taken at the same time every day to be effective.² If someone has a particularly irregular schedule, they can, once they have an established medication routine, talk to their doctor about getting an additional prescription for one of the faster-acting, shorter-duration ADHD medications to fill gaps on days when their medication won't kick in soon enough or when the effects have worn off too early.³

When the medication wears off, a student may find that they just want to zone out and relax, as focusing all day, even with the help of medication, can be exhausting. Unfortunately, this needed respite can lead to feelings of guilt for wasting time and help fuel future procrastination (Quinn, 2001, p. 102).

Working with neurotypical students, LSs often help plan transition times, account for a student's energy levels

1. Time-release versions of the medications also overtook the popularity of the more traditional ADHD stimulants among college students taking them illicitly (without a prescription). They were preferred as the time-release versions reportedly resulted in "fewer ups and downs" (Teter, McCabe, LaGrange, Cranford, & Boyd, 2006).
2. Once they are established on the medication, that is. Doctors usually prefer consistency when figuring out dosages and effectiveness. Another reason a person might want to take it at the same time every day would be if having a routine helps them remember to take it.
3. Your timely author worked with a nursing student who did this. Her shift at the hospital started very early in the morning, and she didn't want to set an alarm for the middle of the night to wake up and take her medication so it would take effect before her shift started. Instead, she took a faster-acting (shorter-duration) medication along with her regular one when she woke up. One medication would wear off in time for the other to take effect.

throughout the day, and decide whether to schedule downtime. A student with ADHD should consider their medication's efficacy window when making those plans.⁴

Measuring Medication Effectiveness

For many, the impact of taking medication for ADHD is immediate and noticeable; they will feel the effect kick in, and just as suddenly, feel it stop working. Other people may wonder whether the medication is working, as the onset or taper-off are more gradual.

The best way to measure medication effectiveness is for a student to work with a healthcare professional. In an ideal situation, their doctor will talk to the patient and send a series of before-and-after rating scales to people who know the patient well. They judge medication efficacy by tracking changes over time. The rating scale method is more common for children, where teachers provide feedback by filling out the scales. Adults don't usually feel comfortable asking those around them (bosses, co-workers, romantic partners) to fill out forms about their executive functioning and how often they are off-task or fail to follow through on commitments.

A more common way for adults to track medication effectiveness is to work with their doctor to identify specific functional areas they believe are affected by ADHD, and then track progress in those areas. Examples might include being on time for appointments, meeting deadlines, finishing started tasks, and remembering to respond to emails.

As many of these functional goals correspond to what an LS would work on with a student, we may be good outside observers of how they are progressing toward these goals over time. Importantly, we shouldn't just go around offering opinions on the effectiveness of their ADHD medication; the student should be talking about this with their doctor. But if a longtime student we know well directly asks for feedback, we could be a potential source of information.

4. See [Scheduling Based on Energy Level](#) for more on scheduling in downtime.

Self-Medication: Caffeine, Nicotine, and Other Substances

An idea that wafts into the public consciousness occasionally is that people with ADHD, especially those who aren't treating their ADHD or who don't yet know they have ADHD, are more likely to “self-medicate” with common stimulants like nicotine and caffeine. This apocryphal bit of wisdom is born of the fact that there are a lot of correlations between people with ADHD and increased coffee and nicotine consumption.

A 2019 study found that there is a linear relationship between the number of ADHD symptoms a person has (i.e. ADHD severity) and the likelihood they will take up smoking (Mitchell et al., 2019). People with ADHD also seem to smoke at a higher rate (Van Amsterdam, van der Velde, Schulte, & van den Brink, 2018). and drink caffeine at a higher rate than people without ADHD (Urbán, Ágoston, Horváth, van den Brink, & Demetrovics, 2022).

The question of whether the mild stimulant effects of caffeine and nicotine can actually help ADHD symptoms is still up in the air. Maybe – maybe not. More research needs to be done.

People with ADHD, like the general population, also self-medicate with other substances like alcohol, marijuana, and illicit drugs. Researchers looking into this relationship have found that over their lifetimes, it's estimated that between 8% and 30% of people with ADHD develop some sort of substance abuse problem (Barkley, R. A., 2021, p. 226), with that number ticking up even higher if alcohol dependence or abuse is included. (Barkley, Murphy, & Fischer, 2008, p. 206) The most popular candidates for abuse after alcohol are cannabis, amphetamines, and cocaine. (Barkley, Murphy, & Fischer, 2008, p. 206)

Looking at it from the other direction, multiple studies on adults and youth have found that people with substance use disorders (SUDs) tend to have ADHD at a much higher rate than the general public (Zulauf, Sprich, Safren, & Wilens, 2014). ADHD is also overrepresented among people in substance abuse treatment programs.¹ One group of researchers looking into it went as far as to recommend that “every patient in an addiction treatment center should be screened at intake for the presence of a comorbid diagnosis of adult ADHD.” (Van de Glind et al., 2020, p. 175)

In a rare bit of good news, it was found that adolescents who used stimulant therapy for ADHD did not differ from population controls in initiating the use of illicit stimulants (cocaine or methamphetamine) later in life. Given the evidence of elevated use of illicit stimulants among those with ADHD in general, this finding suggests that, rather than leading to illicit drug use, stimulant treatment for ADHD may have a potential prophylactic effect (McCabe et al., 2023).

1. The studies looked at by Van de Glind et al. found that approximately 1 in 6 people seeking treatment for substance abuse disorders also had ADHD (Van de Glind et al., 2020).

PART X

SEX, GENDER, AND ADHD

Sex, Gender, and ADHD: It's Complicated

Are there differences between men and women when it comes to ADHD? Yes! And... no! Maybe?! ...It's complicated. As one pair of researchers put it, "We conclude that there is an abundance of conflicting evidence regarding gender differences in many areas of adult ADHD research, and much of the discrepancy may be attributable to referral or diagnostic biases combined with assessment, methodological and statistical challenges that currently work to obscure estimates of true gender effects in both child and adult populations" (Williamson & Johnston, 2015, p. 24).

Compared to the books that have been (and are being) written on this subject, this section will only dip a toe into these waters. Though far from exhaustive, one hopes what follows is still helpful.

Licences with Language

Linguistic potholes abound when it comes to research on sex, gender, and ADHD. Some researchers use “gender” when they mean biological sex, some use “sex” when they mean gender, and some use both interchangeably. Very few writers acknowledge that gender is a social construct independent of biological sex, and fewer still say anything beyond a cursory hat tip to that idea.¹

For the purpose of this summary, when we use the words boy/girl and men/women, we will mean male gender presenting and female gender presenting people (with boy/girl referring to children and men/women to adults). When discussing specific biological differences, the terms male and female will be used here. Those terms also aren’t perfect, as there exists more genetic variety than a simple binary, but, as Hishaw et al. found, it is difficult to discuss the existing research without using the terminology from that research. Hopefully, future researchers will move towards more inclusive ideas and language when discussing sex and gender.

1. The only article referenced here that acknowledges anything more nuanced than a cisgender biological sex dichotomy is Hinshaw, Nguyen, O’Grady, & Rosenthal (2022).

The Invisible Women

Recently, there has been an avalanche of books and articles published on ADHD and women. Some write about ADHD in women as if it is a completely different disorder, like it's its own sports league – the WADHD. According to others, ADHD “manifests in a remarkably similar way in men and women” (Platania, Starreveld, Wynchank, Beekman, & Kooij, 2025, p. 8).

Despite the lack of consensus, this focus on women with ADHD has been a necessary corrective pendulum swing. Until relatively recently, almost all research on ADHD has focused on boys and men, with girls' and women's presentations having been “largely overlooked in both clinical and research settings” (Hinshaw, Nguyen, O'Grady, & Rosenthal, 2022, p. 492). This exclusion isn't unique to ADHD; the history of science and medicine has traditionally ignored anyone who is not a straight white male (Beery & Zucker, 2011).

As we will see, there are some gender correlations with ADHD. But just as we are each shaped by our society's expectations of what boys/girls and women/men are and how they should act, so do those same social expectations of gender influence an individual's experience with ADHD.

Disparity in Diagnostic Numbers

Regardless of how symptoms present, women are much less likely to get diagnosed with ADHD both as children and as adults. The diagnostic ratio in children is estimated to be as high as 10:1, male-to-female (Williamson & Johnston, 2015). In adults, that ratio drops to something in the range of 1.6:1, male to female (Kessler R. et al., 2006).

There are many theories as to why this gender disparity exists (and why it might be changing). As one group of researchers put it, “ADHD manifests in a remarkably similar way in men and women ... [the] delays in diagnosis that have been observed in women may stem less from symptom differences and more from societal factors, such as clinical biases” (Platania, Starreveld, Wynchank, Beekman, & Kooij, 2025, p. 8). The following list, paraphrased from a very good analysis of the subject by Hinshaw et al. 2022, presents theories to explain the gap:

- For a long time, it was “understood” that ADHD was rare among girls and women, and as a result, it wasn't looked for.
- The predominance of the inattentive subtype in girls and women means they are less likely to have visibly impairing symptoms.
- Women and girls have lower rates of co-occurring disruptive disorders (or later onset of same) and can therefore fly under the radar.
- Clinician and teacher bias exists. Rating scale results tend to underrepresent girls even when behaviours are the same across genders. “According to the ‘gender paradox’ (Loeber & Keenan, 1994), the sex with the lower prevalence is expected to display more severe features as well as higher rates of comorbid disorders” (Hinshaw, Nguyen, O'Grady, & Rosenthal, 2022, p. 485).
- Women and girls tend to use “compensatory strategies” at a higher rate, thus masking symptoms.

Likely, the reason that girls/women tend to be diagnosed less often than boys/men is a combination of these factors (and probably a few others not listed here). As awareness of the disorder in girls and women increases, the diagnostic gap has been closing (Simon, Czobor, Bálint, Mészáros, & Bitter, 2009; Young et al., 2020).

Differences in Diagnostic Category

When diagnosed as children, girls are 2.2 times more likely to be diagnosed with ADHD-I than boys (Biederman et al., 2002), and boys are more likely to be diagnosed with ADHD-H than girls (Hinshaw, Nguyen, O'Grady, & Rosenthal, 2022). Among adults, there is less consensus on subtype prevalence by gender. According to one meta study, more women than men meet criteria for ADHD-I (55% vs 49%), and more men meet the criteria for ADHD-C (26% vs 18%) (Willcutt, 2012). However, according to other studies, women may either have a higher prevalence of ADHD-H than men (Salvi et al., 2019), or there may be no significant difference at all in subtype presentations between men and women (Wilens et al., 2009).

Interestingly, the hyperactive symptoms for all genders are less likely to continue into adulthood, whereas inattentive symptoms tend to persist and remain stable (Döpfner et al., 2015). This has been suggested as another reason why, across genders, diagnostic numbers are closer to parity in adults than in children. The theory posits that, since, as one reaches adulthood, ADHD-I is more likely to persist and hyperactive symptoms are more likely to become subdiagnostic, more boys cease to qualify for a diagnosis while the number of girls who continue to qualify remains relatively constant (Hinshaw, Nguyen, O'Grady, & Rosenthal, 2022).

As mentioned in the section on the [different subtypes](#), this tendency of hyperactivity symptoms to lessen as someone ages is why ADHD-H is theorized by some to be an earlier developmental stage of the more common Combined Presentation (Barkley, R. A., 2021, p. 35).

Brain Differences

A 2021 meta-analysis looking at cognitive differences among children and youth with ADHD found “girls with ADHD do not differ from boys with ADHD in many domains of cognitive functioning” (Loyer Carbonneau, Demers, Bigras, & Guay, 2021, p. 11). The areas of similarity were working memory, planning, and attention. The only differences the researchers found were that males tended to be more hyperactive, had less response inhibition, and were worse with cognitive flexibility (Loyer Carbonneau, Demers, Bigras, & Guay, 2021). The tricky question is, which of these qualities actually has a biological basis and which come about because of the social expectations of gender?

There may be a few differences between genders when it comes to working memory, planning and attention in children with ADHD, but things change in adolescence. In *Understanding Girls with ADHD* (2015), Nadeau, Littman, and Quinn note that females’ bodies and brains tend to mature faster than males’. As the prefrontal cortex plays a significant role in executive functioning, its head start, skipping down the hormone-brick road to maturity, often means that females’ executive functioning abilities solidify and become more stable (for better or worse) sooner than males’ (Nadeau, Littman, & Quinn, 2015, pp. 27-29).

Nadeau, Littman, and Quinn also note that male and female brains have differences in the relative sizes of some brain areas. A few areas of the female brain that tend to be larger (proportionally) than they are in the male brain include the caudate, hippocampus, and pallidum. Apparently, the size of these particular areas has been found to be inversely proportional to the degree of hyperactivity observed in people with ADHD (Nadeau, Littman, & Quinn, 2015, pp. 27-29). This could partly explain why many fewer females are diagnosed with the hyperactive subtype than males.

The fact that brains continue to grow and develop into early adulthood, for both males and females, may also explain why it is common for symptoms of hyperactivity and executive functioning weakness to decrease as people get older. People get better at managing those things as they age, both as they learn more compensatory strategies and as the areas of the brain associated with those skills grow and mature.

The decrease in hyperactive symptoms, as mentioned above, combined with the improvement in executive functioning abilities that comes with brain development, can result in some people no longer meeting the diagnostic criteria for ADHD as they age. Since males are more likely to have a diagnosis rooted in hyperactive symptoms, more males than females seem to “age out” of ADHD as they reach adulthood. Women can also “age out,” – but since they tend to mature younger and get diagnosed later, fluctuations in their ADHD presentation may happen before they have been officially diagnosed, making their ADHD seem more stable over time (Nadeau, Littman, & Quinn, 2015, pp. 27-29).

Comorbidities and Gender

“As many as 80% of adults with ADHD have at least one coexisting psychiatric disorder” (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017, p. 1). Various mood disorders, addictions, substance abuse disorders, and personality disorders are sprinkled liberally into these statistics to give the story of ADHD comorbidities an extra heartbreaking *je ne sais quais* (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017).

Compared to the general population, adults with ADHD have a higher likelihood of psychiatric conditions such as Oppositional Defiance Disorder (ODD), Conduct Disorder (CD), tic disorders, anxiety disorders, mood disorders, and substance use disorders (Tsai, Tseng, Yang, & Gau, 2019; Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017; Choi W. W., 2022; Yoshimasu et al., 2018; Solberg et al., 2018). There also seems to be a strong familial link between ADHD and specific comorbid psychiatric conditions. So, if a parent has ADHD and a comorbid anxiety disorder, it is more likely that their child with ADHD will have a similar comorbid anxiety disorder (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017).

A massive study in Norway with over 40,000 people with ADHD found that people with ADHD had a 4-9 times higher prevalence of anxiety disorders, depressive disorders, bipolar disorders, personality disorders, schizophrenia, and substance use disorders than the general population (Solberg et al., 2018). Studies in other countries have found similar numbers (Katzman, Bilkey, Chokka, Fallu, & Klassen, 2017). Getting diagnosed early and sustaining some kind of ADHD treatment for more than 2 years (be it pharmacological or non-pharmacological) reduces the likelihood of a person developing comorbid psychological conditions (Tsai, Tseng, Yang, & Gau, 2019).

In terms of gender differences, women tend to be more likely to have internalizing disorders such as Major Depressive Disorder (MDD), Dysthymia, and Generalized Anxiety Disorder (GAD). Men are more likely to have externalizing disorders such as Substance Use Disorder (SUD), alcohol-related disorders, antisocial disorders, and personality disorders (Yoshimasu et al., 2018). Again, it's likely that, to some extent, these differences arise from social expectations about gender construction rather than anything biological. That is not to say these differences don't exist or shouldn't be taken seriously; it's just that they may only be as universal as society's gender expectations are universal.

PART XI

ADHD STRENGTHS

ADHD Strengths: Juggling Double Edged Knives

It's difficult to talk about the strengths of ADHD both because people with ADHD are not a monolith and because "strengths" are context-dependent. A strength in one situation might be a weakness in another. Impulsivity, for example, is one of the core symptoms of ADHD (American Psychiatric Association, 2013) and can result in people acting without considering the consequences of their actions or starting something without paying close attention to details or instructions. However, when asked about strengths, people list characteristics that flow from that same impulsivity, such as spontaneity, risk-taking, curiosity, and a penchant for novelty (Schippers et al., 2022). The double-edged sword nature of the strengths is a conundrum that online lists of "ADHD Strengths" rarely mention.

As there aren't universal ADHD strengths, the trick, then, is for individuals to learn to work with certain symptoms rather than against them. Dealing with one's ADHD symptoms can be like swimming in a river; it is possible to go against the current, but it's going to be much easier, and one will go much farther, swimming with it.

The weakness-to-strength magic trick isn't always easy (or possible), and it will look different for each person and each situation. Pulling the switch off also requires a high level of metacognitive skills and practical knowledge of how their ADHD tends to manifest in different situations.

General examples of how this could work include some of the strategies we discussed in the [Procrastination and Getting Things Done](#) section: if a student knows they tend to hyperfocus on topics of interest, they could harness that ability by altering or directing the focus of assignments to those topics. If a student knows they have a hard time focusing on one thing at a time, they might take advantage of that insight by starting a few assignments at once and switching between them when their interest wanes.

The Superpower Narrative

It has been popular in the last decade or so to proclaim having ADHD is beneficial, or even a “superpower.” This kind of reframing, though it may be heartening to some people, can also be problematic.

On one hand, social media posts about ADHD as a superpower capture people's attention, which can raise awareness about ADHD. On the other hand, by generalizing hyperbolically, these narratives ignore that people with ADHD are not a homogeneous group. As one author put it, “What happens when ADHDers cannot function in accordance with super-human expectations placed on us owing to false beliefs fueled by narratives about our ‘superpowers’?” (Chatterjee, 2024, p. 2325). Not being able to live up to the social media ideal of ADHD can result in someone thinking that they are a failure because they can't even get ADHD right.

Utilizing these “superpowers” requires privilege and continued access to supports and resources. Many “marginalized ADHDers were not set up for success from an early age and also lack accessible resources and supports required to counter their daily disablement, and become normatively successful, in the present” (Chatterjee, 2024, p. 2326).

Can a student with ADHD leverage some of their symptoms to be an asset in certain situations? Of course. But this isn't a superpower. Cultivating a high level of self-awareness about one's ADHD and one's learning requires continued access to needed supports and the privilege of having enough free time and mental/emotional capacity to do that difficult work.

ADHD and Creativity

Creativity is a good case study of the difficulty of proclaiming universal ADHD “strengths.” Creativity is one of the characteristics that comes up most often when people are asked to self-report the strengths or positive aspects of ADHD (Sedgwick, Merwood, & Asherson, 2018; Schippers et al., 2022).¹

Researchers trying to determine whether creativity correlates with ADHD have had difficulty reaching a consensus. Some say it does (White & Shah, 2011; White & Shah, 2016), some say it doesn’t (Zhu, Zheng, Chen, Zhang, & Liu, 2022), and some say it might, but it’s complicated (White & Shah, 2006; Boot, Nevicka, & Baas, 2020; Stolte et al., 2022).

The fact that there isn’t a single way to measure creativity forces aspiring quants to be creative in their experimental designs. Is creativity best measured by counting a number of self-reported creative achievements, by using convergent and divergent thinking tasks, or by using idea generation tasks? (White & Shah, 2006; Stolte et al., 2022; Boot, Nevicka, & Baas, 2020). Or is it best measured using some kind of standardized creativity rating scales?² (White & Shah, 2011; Zhu, Zheng, Chen, Zhang, & Liu, 2022). Does “innovative thinking” (White & Shah, 2016) count as creativity, or is that something different? Is creativity a self-designation, or is it a subjective label one is given by someone else? Or is it both? Until we can decide what creativity is and how to measure it, it will be hard to “prove” or “disprove” it as a strength of ADHD.

1. Other self-declared positives include traits like being open-minded, flexible, intuitive, analytical, and smart. Longer lists are available in Sedgwick, Merwood, & Asherson (2018), and Schippers et al. (2022).
2. The Torrance Tests of Creative Thinking and the Abbreviated Torrance Test for Adults are the most commonly used

PART XII

ADHD COACHING

ADHD Coaching: Choose your own Adventure

ADHD “coaching” falls into two general camps: private practice coaching and coaching housed in educational institutions. Both tend to focus on helping students achieve certain functional goals and on providing ongoing executive functioning (EF) support (Ahmann & Saviet, 2024).

Many point to Hallowell and Ratey’s book “Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood Through Adulthood,” published in 1994, as the first mention of the idea of ADHD coaching. Hallowell and Ratey are both clinical psychiatrists (and professors), and the coaching they present in their book is solidly rooted in clinical therapy (Hallowell & Ratey, 2011).

Whereas postsecondary institutions that have them set their own hiring criteria for ADHD coaches,¹ there are no set credentials to be a private practice ADHD coach. In searching online for ADHD coaches in southern Ontario in 2026, most are registered psychotherapists, psychologists, or counsellors.

People who lack a credential from a related field sometimes seek out an organization that will, by the power vested in that organization by itself, knight someone a “certified” ADHD coach. These ADHD coaching “certifications” emerged as an offshoot of the life-coaching industry.

As of 2026, there are a number of life-coaching-based organizations (ADD Coach Academy, IACTcenter, Coach Training Institute, etc.) that offer ADHD coaching certifications. These certification processes tend to involve paying money to take a handful of general coaching/life-coaching courses, then paying extra to take specialized ADHD coaching courses. If one doesn’t mind paying even more, some organizations offer the opportunity to level up,² leave the “Basic” ADHD coaches behind, and become an “Advanced” ADHD coach, or even the more rarified “Professional Certified” ADHD coach! (ADD Coach Academy, n.d.; iACTcenter, n.d.; Coach Approach Training Institute, n.d.).³ When it comes to a private-sector ADHD coach, it is up to the consumer to research the coaches they are considering and decide what qualifications they require/are comfortable with.

1. Often, an Education, Psychology, or Psychotherapy degree, along with relevant experience.
2. As one would level up to get a more prestigious belt colour in a strip-mall martial arts program.
3. As of 02/26, these programs run from around 2500 to 14500 CAD.

Evidence of Efficacy

Can it be helpful for a college/university student with ADHD to work with a professional who has experience helping others overcome similar challenges? Of course. Does that need to be specially called ADHD coaching? No. There is a long history of research examining the benefits of learning skills instruction in higher ed.¹ (Hattie, Biggs, & Purdie, 1996; Tuckman & Kennedy, 2011; Heller & Marchant, 2015). This kind of instruction can be useful whether or not the student has ADHD.

The studies looking at the efficacy of “ADHD coaching” for adults primarily look at programs situated in post-secondary institutions. (There hasn’t been much work looking at the efficacy of private practice ADHD coaching.) From an evidence-based standpoint, ADHD coaching (which some call ADHD Executive Function Coaching) is generally agreed to be effective in helping students with ADHD be more successful (Ahmann, Tuttle, Saviet, & Wright, 2018; Ahmann & Saviet, 2021). Some researchers are confident enough in the effectiveness of institutional post-secondary ADHD coaching programs that they have even developed a standardized manual of practice (Ahmann & Saviet, 2024).

Unfortunately, the field of ADHD coaching research is still in its adolescence. There is still little consensus on what successful ADHD coaching looks like, how it should be measured, or even what exactly constitutes “ADHD coaching” (Ahmann, Tuttle, Saviet, & Wright, 2018).

1. There are a lot of different institutional monikers for learning skills instruction support. Departments may help with “learning strategies,” “executive functioning skills,” or “study skills.” More recently, the terms “self-regulated learning strategies” and “self-regulated learning skills” have been thrown around. Though each evolution of the language puts its own spin on the concepts, they generally refer to the same kinds of learning skills (Tressel, Lajoie, & Duffy, 2019).

What's the Difference Between ADHD Coaches and Learning Specialists?

Depending on where and how the service is offered, there might not be much difference between what a student would learn working with an ADHD Coach vs. an LS. Nadeau, Littman, and Quinn, in their book about girls and women with ADHD, write:

“A coach,... gets involved on the nitty-gritty level and helps a girl with the executive functioning difficulties that are so central to ADHD, including: planning her time, setting priorities, organizing assignments, breaking down tasks, and developing effective study skills. In addition, a coach serves as a cheerleader and sounding board, as well as a provider of detailed feedback” (Nadeau, Littman, & Quinn, 2015, p. 254).

If one replaced the word “coach” in the above quote with “learning specialist,” it could double as an LS job description.

Sessions with a private practice ADHD coach who is a registered psychotherapist/psychologist or a clinical psychiatrist may ebb and flow between executive functioning coaching, working towards specific functional goals, and traditional therapy. If the patient is a post-secondary student, they may also apply the strategies they are learning to meet both academic and life goals. A private ADHD coach with a therapy background may work with the student on calendar-ing and time management, but they probably won't be opening the school's e-learning system to help the student dig through course shells for homework and deadlines.

As for us LSs who work in postsecondary education settings, we try to keep the sessions focused on school-based executive functioning support. We may talk about feelings, personal issues, and life struggles, but only to the extent that those things relate to meeting their educational goals.

If a student with ADHD is working with both a private ADHD coach (and/or an ADHD-knowledgeable counsellor/therapist) and an LS, they would be solidly covering both circles in the Venn diagram of how ADHD impacts them in life and at school.

References

- AI Tutor Pro. (2025, 06 20). Retrieved from AI Tutor Pro: <https://www.aitutorpro.ca/>
- Abramovitch, A. P., Dar, R. P., Mittelman, A. B., & Wilhelm, S. P. (2015). Comorbidity Between Attention Deficit/Hyperactivity Disorder and Obsessive-Compulsive Disorder Across the Lifespan. *Harvard Review of Psychiatry*, 23(4), 245-262.
- ADD Coach Academy. (n.d.). *Accredited Coach Training Programs*. (ADD Coach Academy) Retrieved 02 10, 2026, from ADD Coach Academy: <https://addca.com/adhd-coach-training/ADHD-Coach-Training-Programs-Overview/>
- Adler, L., Farahbakhshian, S., Romero, B., Flood, E., & Doll, H. (2019). Healthcare provider perspectives on diagnosing and treating adults with attention-deficit/hyperactivity disorder. *Postgraduate Medicine*, 131(7), 461-472.
- Ahmann, E., & Saviet, M. (2021). ADHD Coaching: Evolution of the Field. *The ADHD Report*, 29(6).
- Ahmann, E., & Saviet, M. (2024). Development of a Manualized Coaching Intervention for Adult ADHD. *International Journal of Evidence Based Coaching and Mentoring*, 22(1), 177-198.
- Ahmann, E., Tuttle, L. J., Saviet, M., & Wright, S. D. (2018). A Descriptive Review of ADHD Coaching Research: Implications for College Students. *Journal of Postsecondary Education and Disability*, 31(1), 17-39.
- Altgassen, M., Scheres, A., & Edel, M. A. (2019). Prospective memory (partially) mediates the link between ADHD symptoms and procrastination. *ADHD Attention Deficit and Hyperactivity Disorders*, 11(1), 59-71.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).
- Anderson, C. (2003). The Psychology of Doing Nothing: Forms of Decision Avoidance Result From Reason and Emotion. *Psychological Bulletin*, 129(1), 139.
- Anker, E., Ogrim, G., & Heir, T. (2022). Verbal working memory and processing speed: Correlations with the severity of attention deficit and emotional dysregulation in adult ADHD. *Journal of Neuropsychology*, 16(1), 211-235.
- Arnold, L., Hodgkins, P., Kahle, J., Madhoo, M., & Kewley, G. (2020). Long-term outcomes of ADHD: academic achievement and performance. *Journal of attention disorders*, 24(1), 73-85.
- Ashinoff, B. A.-A. (2021). Hyperfocus: the forgotten frontier of attention. *Psychological Research*, 85, 1-19.
- Atlas, G. D. (1994). Sensitivity to Criticism: A New Measure of Responses to Everyday Criticisms. *Journal of Psychoeducational Assessment*, 12(3).
- August, G. J., & Garfinkel, B. D. (1990). Comorbidity of ADHD and reading disability among clinic-referred children. *Journal of Abnormal Child Psychology*, 18, 29-45.
- Barkley, R. A. (1997). Behavioral inhibition, sustained attention, and executive functions: constructing a unifying theory of ADHD. *Psychological bulletin*, 121(1), 65.
- Barkley, R. A. (2015). A Theory of ADHD. In R. A. Barkley, *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment* (pp. 297-334). New York: Guilford.
- Barkley, R. A. (2021). *Taking Change of Adult ADHD: proven strategies to succeed at work, at home, and in relationships*. Guilford Publications.
- Barkley, R. A., Cook, A., Diamond, A., Zametkin, A., Thapar, A., & Teeter, A. (2002). International Consensus Statement on ADHD. *Clinical Child and Family Psychology Review*, 5(2), 89-111.
- Barkley, R. A., Murphy, K. R., & Fischer, M. (2008). *ADHD in Adults: What the Science Says*. New York: The Guilford Press.
- Beaton, D., Sirois, F., & Milne, E. (2020). Self-compassion and perceived criticism in adults with attention deficit hyperactivity disorder (ADHD). *Mindfulness*, 11(11), 2506-2518.
- Beaton, D., Sirois, F., & Milne, E. (2022). Experiences of criticism in adults with ADHD: A qualitative study. *Plos one*, 17(2).
- Beery, A., & Zucker, I. (2011). Sex bias in neuroscience and biomedical research. *Neuroscience & Biobehavioral Reviews*, 35(3), 565-572.
- Biederman, J., Faraone, S. V., Spencer, T., Wilens, T., Norman, D., Lapey, K. A., . . . Doyle, A. (1993). Patterns of psychiatric comorbidity, cognition and psychosocial functioning in adults with attention deficit/hyperactivity disorder. *American Journal of Psychiatry*, 150(12), 1792-1798.

- Biederman, J., Mick, E., Faraone, S. V., Braaten, E., Doyle, A., Spencer, T., . . . Johnson, M. (2002). Influence of gender on attention deficit hyperactivity disorder in children referred to a psychiatric clinic. *American Journal of psychiatry*, 59(1), 36-42.
- Biederman, J., Monuteaux, M. C., Spencer, T., Wilens, T. E., & Faraone, S. V. (2009). Do Stimulants Protect Against Psychiatric Disorders in Youth With ADHD? A 10-Year Follow-up Study. *Pediatrics*, 124(1), 71-78.
- Bijlenga, D., Vollebregt, M., Kooij, J., & Arns, M. (2019). The role of the circadian system in the etiology and pathophysiology of ADHD: time to redefine ADHD? *ADHD Attention Deficit and Hyperactivity Disorders*, 11(1), 5-19.
- Boot, N., Nevicka, B., & Baas, M. (2020). Creativity in ADHD: goal-directed motivation and domain specificity. *Journal of attention disorders*, 24(13), 1857-1866.
- Bruck, M. (1990). Word-recognition skills of adults with childhood diagnoses of dyslexia. *Developmental psychology*, 26(3), 439.
- Bruck, M. (1992). Persistence of dyslexics' phonological awareness deficits. *Developmental psychology*, 28(5), 874.
- Canela, C., Buadze, A., Dube, A., Eich, D., & Liebreinz, M. (2017). Skills and compensation strategies in adult ADHD-A qualitative study. *PloS one*, 12(9).
- Canu, W., Stevens, A., Ranson, L., Lefler, E., LaCount, P., Serrano, J., . . . Hartung, C. (2021). College readiness: Differences between first-year undergraduates with and without ADHD. *Journal of learning disabilities*, 54(6), 403-411.
- Chatterjee, S. (2024). ADHD as entrepreneurial neurodivergence: re-evaluating 'ADHD superpowers,' revealing its connections with capitalism. *Disability & Society*, 40(8), 2322-2327.
- Chiu, Y., Chang, H., Johnston, A., Nascimento, M., Herbert, J., & Niu, X. (2019). Impact of Disability Services on Academic Achievement among College Students with Disabilities. *Journal of Postsecondary Education and Disability*, 32(3), 227-245.
- Choi, W. S., Woo, Y. S., Wang, S. M., Lim, H. K., & Bahk, W. M. (2022). The prevalence of psychiatric comorbidities in adult ADHD compared with non-ADHD populations: A systematic literature review. *PloS one*, 17(11).
- Choi, W. W. (2022). The prevalence of psychiatric comorbidities in adult ADHD compared with non-ADHD populations: A systematic literature review. *PloS one*, 17(11), PloS one.
- Chung, K., Lee, C., Yeung, W., Chan, M., Chung, E., & Lin, W. (2018). Sleep hygiene education as a treatment of insomnia: a systematic review and meta-analysis. *Family practice*, 35(4), 365-375.
- Chung, P., Patel, D., & Nizami, I. (2020). Disorder of written expression and dysgraphia: definition, diagnosis, and management. *Translational pediatrics*, 9(Suppl 1), s46.
- Coach Approach Training Institute. (n.d.). *Our Coaching Credentials*. Retrieved 02 10, 2026, from Coach Approach Institute: <https://coachapproachtraining.com/icf-coaching-credentials/>
- D'Agati, E., Curatolo, P., & Mazzone, L. (2017). Comorbidity between ADHD and anxiety disorders across the lifespan. *International Journal of Psychiatry in Clinical Practice*, 23(4), 238-244.
- De Pasquale, C., El Kazzi, M., Sutherland, K., Shriane, A., Vincent, G., Cistulli, P., & Bin, Y. (2024). Sleep hygiene-What do we mean? A bibliographic review. *Sleep hygiene-What do we mean? A bibliographic review*, 75, 101930.
- Dietrich, S., Francis-Jimenez, C., Knibbs, M., Umali, I., & Truglio-Londrigan, M. (2016). Effectiveness of sleep education programs to improve sleep hygiene and/or sleep quality in college students: a systematic review. *JB I Evidence Synthesis*, 14(9), 108-134.
- Dodson, W. W. (2006). Real-World Office Management of ADHD in Adults. *Psychiatric Times*, 23(13), 37. Retrieved from <http://ra.ocls.ca/ra/login.aspx?inst=conestoga&url=https://www.proquest.com/trade-journals/real-world-office-management-adhd-adults/docview/204631526/se-2>
- Dodson, W. W. (2024, 11 01). *Three Defining Features of ADHD That Everyone Overlooks*. Retrieved from ADDitude: <https://www.additudemag.com/symptoms-of-add-hyperarousal-rejection-sensitivity/>
- Dodson, W., Modestino, E., Ceritoğlu, H., & Zayed, B. (2024). Rejection sensitivity dysphoria in attention-deficit/hyperactivity disorder: A case series. *Neurology*, 7, 23-30.
- Donfrancesco, R., Di Trani, M., Porfirio, M. C., Giana, G., Miano, S., & Andriola, E. (2015). Might the temperament be a bias in clinical study on attention-deficit hyperactivity disorder (ADHD)?: Novelty Seeking dimension as a core feature of ADHD. *Psychiatry research*, 227(2-3), 333-338.
- Döpfner, M., Hautmann, C., Görtz-Dorten, A., Klasen, F., Ravens-Sieberer, U., & Group, B. S. (2015). Long-term course

of ADHD symptoms from childhood to early adulthood in a community sample. *European child & adolescent psychiatry*, 24(6), 665-673.

Downey, G., & Feldman, S. I. (1996). Implications of rejection sensitivity for intimate relationships. *Journal of Personality and Social Psychology*, 70(6), 1327-1342.

Doyle, A., Healy, O., Paterson, J., Lewis, K., & Treanor, D. (2024). What does an ADHD-friendly university look like? A case study from Ireland. *International Journal of Educational Research Open*, 7.

Dr. Edward Hallowell and the Hallowell Centers. (n.d.). *ADHD and Time*. Retrieved 07 2025, from Dr. Edward Hallowell and the Hallowell Centers: <https://drhallowell.com/2018/03/02/adhd-and-time-2/>

DuPaul, G., Dahlstrom-Hakki, I., Gormley, M., Fu, Q., Pinho, T., & Banerjee, M. (2017). College students with ADHD and LD: Effects of support services on academic performance. *Learning Disabilities Research & Practice*, 32(4), 246-256.

DuPaul, G., Gormley, M., Anastopoulos, A., Weyandt, L., Labban, J., Sass, A., . . . Postler, K. (2021). Academic trajectories of college students with and without ADHD: Predictors of four-year outcomes. *Journal of Clinical Child & Adolescent Psychology*, 50(6), 828-843.

Eagle, T., Baltaxe-Admony, L. B., & Ringland, K. E. (2024). "It was something I naturally found worked and heard about later": An Investigation of Body Doubling with Neurodivergent Participants. *ACM Transactions on Accessible Computing*, 17(3), 1-30.

Edmondson, A. B., & House, A. (2016). Non-suicidal reasons for self-harm: A systematic review of self-reported accounts. *Journal of affective disorders*, 191, 109-117.

Edwards, M., Poed, S., Al-Nawab, H., & Penna, O. (2022). Academic accommodations for university students living with disability and the potential of universal design to address their needs. *Higher education*, 84(4), 779-799.

Espinet, S. D., Graziosi, G., Toplak, M. E., Hesson, J., & Minhas, P. (2022). A Review of Canadian Diagnosed ADHD Prevalence and Incidence Estimates Published in the Past Decade. *Brain Sciences*, 8, 1051.

Fadeuilhe, C., Daigre, C., Richarte, V., Grau-López, L., Palma-Álvarez, R., Corrales, M., & Ramos-Quiroga, J. (2021). Insomnia disorder in adult attention-deficit/hyperactivity disorder patients: clinical, comorbidity, and treatment correlates. *Frontiers in psychiatry*, 12, 663889.

Freedman, J., & Honkasilta, J. (2017). Dictating the boundaries of ab/normality: a critical discourse analysis of the diagnostic criteria for attention deficit hyperactivity disorder and hyperkinetic disorder. *Disability & Society*, 32(4), 565-588.

Friedman, N. P., & Robbins, T. W. (2022). The role of prefrontal cortex in cognitive control and executive function. *Neuropsychopharmacology*, 47(1), 72-89.

Gaye, F., Harmon, S. L., Cole, A. M., Marsh, C. L., Liu, Q., McIntosh, A., & K. M. (2025). Examining the Roles of Working Memory and Trait Anxiety on Math Achievement in Children With ADHD. *Neuropsychology*, 39(3), 259-274.

Ginapp, C. M., Greenberg, N. R., MacDonald-Gagnon, G., Angarita, G. A., Bold, K. W., & Potenza, M. N. (2023). "Dysregulated not deficit": A qualitative study on symptomatology of ADHD in young adults. *PloS one*, 18(10).

Girard, R., & Joobar, R. (2017). Treatment of ADHD in patients with bipolar disorder. *Journal of Psychiatry and Neuroscience*, 42(6), E11-E12.

Goldstein, A. L., Shifrin, A., Katz, J. L., Iu, L. K., & Kofler, D. (2021). Exploring the relationship between ADHD symptoms and daily cannabis consequences in emerging adulthood: The role of cannabis motives. *Journal of Studies on Alcohol and Drugs*, 82(2), 228-236.

Graham, S., Fishman, E. J., Reid, R., & Hebert, M. (2016). Writing Characteristics of Students with Attention Deficit Hyperactive Disorder: A Meta-Analysis. *Learning Disabilities Research and Practice*, 31(2), 75-89.

Gualtieri, C. T. (2002). The Static Neurobehavioral Syndromes. In C. T. Gualtieri, *Brain injury and mental retardation: psychopharmacology and neuropsychiatry* (pp. 123-150). Baltimore: Lippincott Williams & Wilkins.

Hallowell, E. M. (2024, 11 29). ADHD – How it Manifests and Effective Steps to Address It. *McMaster University Alumni Webinar Series*. Retrieved from McMaster University Alumni: <https://alumlc.org/mcmaster/31604>

Hallowell, E. M., & Ratey, J. J. (2010). *Answers to Distraction*. Anchor.

Hallowell, E. M., & Ratey, J. J. (2011). *Driven to distraction (revised): recognizing and coping with attention deficit disorder*. Vintage.

- Hansson Halleröd, H. L., Anckarsäter, H., Råstam, M., & Hansson Scherman, M. (2015). Experienced consequences of being diagnosed with ADHD as an adult—a qualitative study. *BMC Psychiatry*, 15(1), 31.
- Hattie, J., Biggs, J., & Purdie, N. (1996). Effects of learning skills interventions on student learning: A meta-analysis. *Review of educational research*, 66(2), 99-136.
- Heller, M. L., & Marchant, G. J. (2015). Facilitating Self-Regulated Learning Skills and Achievement With a Strategic Content Learning Approach. *Community College Journal of Research and Practice*, 39(9), 808-818.
- Hinshaw, S., Nguyen, P., O'Grady, S., & Rosenthal, E. (2022). Annual Research Review: Attention-deficit/hyperactivity disorder in girls and women: underrepresentation, longitudinal processes, and key directions. *Journal of Child Psychology and Psychiatry*, 63(4), 484-496.
- Hogan, A. J. (2019). Social and medical models of disability and mental health: evolution and renewal. *Canadian Medical Association Journal*, 191(1), E16-E18.
- Hupfeld, K. A. (2019). Living “in the zone”: hyperfocus in adult ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, 11, 191-208.
- Hutchins, E. (2000). Distributed cognition. *International encyclopedia of the social and behavioral sciences*, 138(1), 1-10.
- iACTcenter. (n.d.). *ADHD Coaching Certification*. Retrieved 02 10, 2026, from iACTcenter: <https://www.iactcenter.com/coach-training/>
- It's Borture! What ADHD Boredom Really Feels Like. (2024, 11 01). Retrieved from ADDITUDE: <https://www.additudemag.com/slideshows/i-am-bored-agitation-restlessness/>
- Katzman, M., Bilkey, T., Chokka, P., Fallu, A., & Klassen, L. (2017). Adult ADHD and comorbid disorders: clinical implications of a dimensional approach. *BMC psychiatry*, 17(1), 1-15.
- Kaushal, P. S., Saran, B., Bazaz, A., & Tiwari, H. (2024). A brief review of limbic system anatomy, function, and its clinical implication. *Santosh University Journal of Health Sciences*, 10(1), 26-32.
- Kercood, S., & Banda, D. R. (2012). The effects of added physical activity on performance during a listening comprehension task for students with and without attention problems. *International Journal of Applied Educational Studies*, 13(1), 19.
- Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., . . . Walters, E. E. (2005). The World Health Organization adult ADHD self-report scale (ASRS): a short screening scale for use in the general population. *Psychological Medicine*, 35(2).
- Kessler, R., Adler, L., Barkley, R., Biederman, J., Conners, C., Demler, O., . . . Spencer, T. (2006). The prevalence and correlates of adult ADHD in the United States: results from the National Comorbidity Survey Replication. *American Journal of psychiatry*, 163(4), 716-723.
- Kim, H., & Jung, N. (2025). Mindfulness-based interventions for adults with ADHD: A systematic review and meta-analysis. *Medicine*, 104(37), e44308.
- Kingsdorf, S., & Krawec, J. (2014). Error analysis of mathematical word problem solving across students with and without learning disabilities. *Learning Disabilities Research & Practice*, 29(2), 66-74.
- Knouse, L. E. (2014). Cognitive-behavioral therapies for ADHD. In R. A. Barkley (Ed.), *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment* (4th ed., pp. 757-773). New York: Guilford Press.
- Kysow, K., Park, J., & Johnston, C. (2017). The use of compensatory strategies in adults with ADHD symptoms. *ADHD Attention Deficit and Hyperactivity Disorders*(9), 73-88.
- Lanier, J., Noyes, E., & Biederman, J. (2021). Mind wandering (internal distractibility) in ADHD: A literature review. *Journal of attention disorders*, 25(6), 885-890.
- Letšosa, R., & Retief, M. (2018). Models of disability: A brief overview. *HTS: Theological Studies*, 74(1), 1-8.
- Lindquist, E., Aviv, E., Magner-Parsons, B., Woodward, D., West, A., & Bravo, A. (2025). 70% of College Students Who Engage in Non-Suicidal Self-injury Do Not Seek Treatment: An International Study. *International Journal of Mental Health and Addiction*, 1-14.
- Loeber, R., & Keenan, K. (1994). Interaction between conduct disorder and its comorbid conditions: Effects of age and gender. *Clinical psychology review*, 14(6), 497-523.
- Loyer Carbonneau, M., Demers, M., Bigras, M., & Guay, M. (2021). Meta-analysis of sex differences in ADHD symptoms and associated cognitive deficits. *Journal of attention disorders*, 12, 1640-1656.

- Mak, A., Lee, S., Sampson, N., Albor, Y., Alonso, J., Auerbach, R., . . . Ebert, D. (2022). ADHD comorbidity structure and impairment: Results of the WHO world mental health surveys international college student project. *Journal of attention disorders*, 26(8), 1078-1096.
- Martín-Rodríguez, A., Herrero-Roldán, S., & Clemente-Suárez, V. J. (2025). The Role of Physical Activity in ADHD Management: Diagnostic, Digital and Non-Digital Interventions, and Lifespan Considerations. *Children*, 12(3), 338.
- Mayes, S., Frye, S., Breaux, R., & Calhoun, S. L. (2018). Diagnostic, Demographic, and Neurocognitive Correlates of Dysgraphia in Students with ADHD, Autism, Learning Disabilities, and Neurotypical Development. *Journal of Developmental and Physical Disabilities*, 30, 489-507.
- McCabe, S. E., Schulenberg, J. E., Wilens, T. E., Schepis, T. S., McCabe, V. V., & Veliz, P. T. (2023). Cocaine or methamphetamine use during young adulthood following stimulant use for attention-deficit/hyperactivity disorder during adolescence. *JAMA Network Open*, 6(7).
- Metcalfe, L. B., McFeaters, C. D., & Voyer, D. (2024). Time-Perception Deficits in Attention-Deficit/Hyperactivity Disorder: A Systematic Review and Meta-Analysis. *Developmental Neuropsychology*, 49(1), 1-24.
- Mette, C. (2023). Time Perception in Adult ADHD: Findings from a Decade – A Review. *International Journal of Environmental Research and Public Health*, 4.
- Mitchell, J., Howard, A., Belendiuk, K., Kennedy, T., Stehli, A., Swanson, J., . . . Lu, B. (2019). Cigarette smoking progression among young adults diagnosed with ADHD in childhood: A 16-year longitudinal study of children with and without ADHD. *Nicotine and Tobacco Research*, 21(5), 638-647.
- Mowinckel, A. M., Pedersen, M. L., Eilertsen, E., & Biele, G. (2015). A meta-analysis of decision-making and attention in adults with ADHD. *Journal of attention disorders*, 19(5), 355-367.
- Müller, V., Mellor, D., & Pikó, B. (2024). Associations between ADHD symptoms and rejection sensitivity in college students: Exploring a path model with indicators of mental well-being. *Learning Disabilities Research & Practice*, 39(4), 223-236.
- Nadeau, K., Littman, E., & Quinn, P. (2015). *Understanding Girls with ADHD, Updated and Revised: How they feel and why they do what they do*. Washington D.C.: Advantage Books.
- Newcorn, J., Krone, B., & Dittmann, R. (2022). Nonstimulant treatments for ADHD. *Child and Adolescent Psychiatric Clinics of North America*, 31(3), 417-435.
- Newman, L., & Madaus, J. (2015). Reported accommodations and supports provided to secondary and post-secondary students with disabilities: National perspective. *Career Development and Transition for Exceptional Individuals*, 38(3), 173-181.
- Oroian, B., Nechita, P., & Szalontay, A. (2025). ADHD and Decision Paralysis: Overwhelm in a World of Choices. *European Psychiatry*, 68(S1).
- Pagespetit, È., Pagerols, M., Barrés, N., Prat, R., Martínez, L., Andreu, M., . . . Bosch, R. (2025). ADHD and academic performance in college students: A systematic review. *Journal of Attention Disorders*, 29(4), 281-197.
- Parker, D. R., Field Hoffman, S., Sawilowsky, S., & Rolands, L. (2011). An Examination of the Effects of ADHD Coaching on University Students' Executive Functioning. *Journal of Postsecondary Education and Disability*, 24(2), 115-132.
- Platania, N., Starreveld, D., Wynchank, D., Beekman, A., & Kooij, S. (2025). Bias by gender: exploring gender-based differences in the endorsement of ADHD symptoms and impairment among adult patients. *Frontiers in Global Women's Health*, 6, 1549028.
- Pychyl, T. A. (2013). *Solving the procrastination puzzle: A concise guide to strategies for change*. TarcherPerigee.
- Quinn, P. O. (2001). *ADD and the College Student: A Guide for High School and College Students with Attention Deficit Disorder*. Washington D.C.: American Psychological Association.
- Ratey, J. J. (2008). *Spark: The revolutionary new science of exercise and the brain*. Little, Brown Spark.
- Riemann, D., Espie, C., Altena, E., Arnardottir, E., Baglioni, C., Bassetti, C., . . . Dolenc Groselj, L. (2023). The European Insomnia Guideline: An update on the diagnosis and treatment of insomnia. *Journal of sleep research*, 32(6), e14035.
- Rivas-Vazquez, R., Diaz, S., Visser, M., & Rivas-Vazquez, A. (2023). Adult ADHD: underdiagnosis of a treatable condition. *Journal of health service psychology*, 49(1), 11-19.

- Rowney-Smith, A., Sutton, B., Quadt, L., & Eccles, J. (2026). The lived experience of rejection sensitivity in ADHD-a qualitative exploration. *PLoS One*, 2(1).
- Safren, S. A., Sprich, S. E., Perlman, C. A., & Otto, M. W. (2017). *Mastering Your Adult ADHD: A Cognitive-Behavioral Treatment Program, Therapist Guide*. Oxford University Press.
- Salvi, V., Migliarese, G., Venturi, V., Rossi, F., Torriero, S., Viganò, V., . . . Mencacci, C. (2019). ADHD in adults: clinical subtypes and associated characteristics. *Rivista Di Psichiatria*, 54(2), 84-89.
- Sandland, B. (2025). Neurodivergent Experiences of Rejection Sensitive Dysphoria Expose the Environmental Factors too Often Overlooked. *Neurodiversity*, 3.
- Saul, R. (2014, March 14). Doctor: ADHD Does Not Exist. Retrieved from Time Magazine: <https://time.com/25370/doctor-adhd-does-not-exist/>
- Schippers, L., Horstman, L. V., Pereira, R., Zinkstok, J., Mostert, J., Greven, C., & Hoogman, M. (2022). A qualitative and quantitative study of self-reported positive characteristics of individuals with ADHD. *Frontiers in Psychiatry*, 13.
- Schoenen, E. C., Alsip, B. S., Martinez, J. C., Grekov, P., Aspiranti, K. B., & Hulac, D. M. (2025). A meta-analysis of fidget devices as academic and behavioral interventions. *School Psychology Review*, 54(3), 315-327.
- Sedgwick, J. A., Merwood, A., & Asherson, P. (2018). The positive aspects of attention deficit hyperactivity disorder: a qualitative investigation of successful adults with ADHD. *ADHD Attention Deficit and Hyperactivity Disorders*, 11(13), 241-253.
- Semrund-Clikeman, M., & Bledsoe, J. (2011). Updates on Attention-Deficit/Hyperactivity Disorder and Learning Disorders. *Current psychiatry reports*, 13(5), 354-373.
- Shaywitz, S., Holahan, J., Kenney, B., & Shaywitz, B. (2020). The Yale outcome study: Outcomes for graduates with and without dyslexia. *Journal of Pediatric Neuropsychology*, 6(4), 189-187.
- Shimko, G. A., & James, K. H. (2025). The effects of notetaking modality and symptoms of attention-deficit/hyperactivity disorder (ADHD) on learning. *Educational Psychology*, 45(5), 541-560.
- Simon, V., Czobor, P., Bálint, S., Mészáros, A., & Bitter, I. (2009). Prevalence and correlates of adult attention-deficit hyperactivity disorder: meta-analysis. *The British journal of psychiatry*, 194(3), 204-211.
- Smaniotto, L., Tolentino, A., Barros, F., Barreto, E., Colnaghi, B., Ker, L., . . . Azevedo, R. (2026). Non-Suicidal Self-Injury in Individuals with Attention-Deficit/Hyperactivity Disorder: A Systematic Review and Meta-Analysis with Age- and Sex-Stratified Findings. *Psychiatry Research*, 116975.
- Sobanski, E., Brüggemann, D., Alm, B., Kern, S., Deschner, M., Schubert, T., . . . Rietschel, M. (2007). Psychiatric comorbidity and functional impairment in a clinically referred sample of adults with attention-deficit/hyperactivity disorder. *European Archives of Psychiatry and Clinical Neuroscience*, 257(7), 371-377.
- Solanto, M. V. (2011). *Cognitive-Behavioral Therapy for Adult ADHD: Targeting Executive Dysfunction*. New York: Guilford Press.
- Solberg, B., Halmøy, A., Engeland, A., Igland, J., Haavik, J., & Klungsøyr, K. (2018). Gender differences in psychiatric comorbidity: a population-based study of 40 000 adults with attention deficit hyperactivity disorder. *Acta Psychiatrica Scandinavica*, 137(3), 176-186.
- Somer, E., Soffer-Dudek, N., & Ross, C. A. (2017). The comorbidity of daydreaming disorder (maladaptive daydreaming). *The Journal of Nervous and Mental Disease*, 205(7), 525-530.
- Srivastava, S. (2022). On Terms: What's in a Name? Intellectual Disability and "Condition," "Disorder," "Syndrome," "Disease," and "Disability". *American Journal on Intellectual and Developmental Disabilities*, 127(5), 349-354.
- Stevens, A., Abu-Ramadan, T., & Hartung, C. (2022). Promoting academic success in college students with ADHD and LD: A systematic literature review to identify intervention targets. *Journal of American College Health*, 70(8), 2342-2355.
- Stolte, M., Trindade-Pons, V., Vlaming, P., Jakobi, B., Franke, B., Kroesbergen, E., . . . Hoogman, M. (2022). Characterizing creative thinking and creative achievements in relation to symptoms of attention-deficit/hyperactivity disorder and autism spectrum disorder. *Frontiers in Psychiatry*, 13.
- Swannell, S., Martin, G., Page, A., Hasking, P., & St John, N. (2014). Prevalence of nonsuicidal self-injury in nonclinical samples: Systematic review, meta-analysis and meta-regression. *Suicide and Life-Threatening Behavior*, 44(3), 273-303.
- Teter, C. J., McCabe, S. E., LaGrange, K., Cranford, J. A., & Boyd, C. J. (2006). Illicit use of specific prescription stimulants

among college students: prevalence, motives, and routes of administration. *Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy*, 26(10), 1501-1510.

Thapa, P. T., Khadka, N., Bhattarai, R., Jha, S., Khanal, A., & Basnet, B. (2018). YouTube lens to attention deficit hyperactivity disorder: a social media analysis. *BMC Research Notes*, 11(1), 1-6.

Theodor-Katz, N., Somer, E., Hesse, R. M., & Soffer-Dudek, N. (2022). Could immersive daydreaming underlie a deficit in attention? The prevalence and characteristics of maladaptive daydreaming in individuals with attention-deficit/hyperactivity disorder. *Journal of Clinical Psychology*, 78(11), 2309-2328.

Toutain, C. (2019). Barriers to accommodations for students with disabilities in higher education: A literature review. *Journal of Postsecondary Education and Disability*, 32(3), 297-310.

Tressel, T., Lajoie, S. P., & Duffy, M. C. (2019). A Guide for Study Terminology: Reviewing a Fragmented Domain. *Canadian Psychology = Psychologie Canadienne*, 60(2), 115-127.

Tsai, F., Tseng, W., Yang, L., & Gau, S. (2019). Psychiatric comorbid patterns in adults with attention-deficit hyperactivity disorder: treatment effect and subtypes. *PloS one*, 14(2), e0211873.

Tuckman, B. W., & Kennedy, G. J. (2011). Teaching Learning Strategies to Increase Success in First-Term College Students. *Journal of Experimental Education*, 79, 478-504.

Tufnel, N. (1984). *This is Spinal Tap*. (M. DiBergi, Interviewer) Embassy Pictures.

Urbán, R., Ágoston, C., Horváth, Z., van den Brink, W., & Demetrovics, Z. (2022). Self-Medication of ADHD Symptoms: Does Caffeine Have a Role? *Frontiers in Psychiatry*, 13.

Vaa, T. (2012). ADHD and relative risk of accidents in road traffic: A meta-analysis. *Accident Analysis and Prevention*, 62, 415-425.

Van Amsterdam, J., van der Velde, B., Schulte, M., & van den Brink, W. (2018). Causal Factors of Increased Smoking in ADHD: A Systematic Review. *SUBSTANCE USE & MISUSE*, 53(3), 432-445.

Van de Glind, G., Brynte, C., Skutle, A., Kaye, S., Konstenius, M., Levin, F., . . . Schellekens, A. (2020). The international collaboration on ADHD and substance abuse (ICASA): mission, results, and future activities. *European Addiction Research*, 26(4-5), 173-178.

Voyer, D., Ronis, S. T., & Byers, N. (2022). The effect of notetaking method on academic performance: A systematic review and meta-analysis. *Contemporary Educational Psychology*, 68.

Wajszilber, D., Santiseban, J., & Gruber, R. (2018). Sleep disorders in patients with ADHD: impact and management challenges. *Nature and science of sleep*, 453-480.

Weinstein, C., Palmer, D., & Acee, T. (2016). *LASSI User's Manual Learning and Study Strategies Inventory* (3rd Edition ed.). H & H Publishing Company. Retrieved from <https://www.hhpublishing.com/LASSImanual.pdf>

White, H. A., & Shah, P. (2011). Creative style and achievement in adults. *Personality and Individual Differences*, 50, 673-677.

White, H., & Shah, P. (2006). Uninhibited imaginations: Creativity in adults with Attention-Deficit/Hyperactivity Disorder. *Personality and Individual Differences*, 40, 1121-1131.

White, H., & Shah, P. (2016). Scope of Semantic Activation and Innovative Thinking in College Students with ADHD. *Creativity Research Journal*, 28(3), 275-282.

Wilens, T., Biederman, J., Faraone, S., Martelon, M., Westerberg, D., & Spencer, T. (2009). Presenting ADHD symptoms, subtypes, and comorbid disorders in clinically referred adults with ADHD. *Journal of Clinical Psychiatry*, 70(11), 1557.

Willcutt, E. G. (2012). The Prevalence of DSM-IV Attention-Deficit/Hyperactivity Disorder: A Meta-Analytic Review. *Neurotherapeutics*, 9(3), 490-9.

Willcutt, E. G., & Pennington, B. F. (2000). Comorbidity of Reading Disability and Attention-Deficit/Hyperactivity Disorder: Differences by Gender and Subtype. *Journal of Learning Disabilities*, 33(2), 179-191.

Willcutt, E. G., Betjemann, R. S., Pennington, B. F., Olson, R. K., DeFries, J. C., & Wadsworth, S. J. (2007). Longitudinal study of reading disability and attention-deficit/hyperactivity disorder: Implications for education. *Mind, Brain, and Education*, 1(4), 181-102.

Williamson, D., & Johnston, C. (2015). Gender Differences in Adults with Attention-Decficit/Hyperactivity Disorder: A Narrative Review. *Clinical Psychology Review*, 40, 15-27.

- Williamson, D., & Johnston, C. (2015). Gender differences in adults with attention-deficit/hyperactivity disorder: A narrative review. *Clinical Psychology Review*, 40, 15-27.
- Wohl, M., Pychyl, T., & Bennett, S. (2010). I forgive myself, now I can study: How self-forgiveness for procrastinating can reduce future procrastination. *Personality and individual differences*, 48(7), 803-808.
- Wolraich, M. L., Hagan, J. F., Allan, C., Chan, E., Davison, D., Earls, M., . . . Zurhellen, W. (2019). Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*, 144(4).
- Yeung, A., Ng, E., & Abi-Jaoude, E. (2022). TikTok and attention-deficit/hyperactivity disorder: a cross-sectional study of social media content quality. *The Canadian Journal of Psychiatry*, 67(12), 899-906.
- Yoshimasu, K., Barbaresi, W., Colligan, R., Voigt, R., Killian, J., Weaver, A., & . Katusic, S. (2018). Adults with persistent ADHD: Gender and psychiatric comorbidities—A population-based longitudinal study. *Journal of attention disorders*, 22(6), 535-546.
- Young, S., Adamo, N., Ásgeirsdóttir, B., Branney, P., Beckett, M., Colley, W., . . . Hill, P. (2020). Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/hyperactivity disorder in girls and women. *BMC psychiatry*, 20(1), 404.
- Zalsman, G., & Shilton, T. (2016). Adult ADHD: A new disease? *Journal of Psychiatry in Clinical Practice*, 20(2), 70-76.
- Zhu, X., Zheng, H., Chen, K., Zhang, Y., & Liu, Y. (2022). Meta Analysis of the Relationship between ADHD Children and Creativity. *International Conference on Science and Technology Ethics and Human Future* (pp. 188-192). Atlantis Press.
- Zulauf, C. A., Sprich, S. E., Safren, S. A., & Wilens, T. E. (2014). The Complicated Relationship Between Attention Deficit/Hyperactivity Disorder and Substance Use Disorders. *Current Psychiatry Reports*, 16, 1-11.