Navigating Stigma & Identity: Lived Experiences of Neurodivergent (ADHD) Young Asian Women in Aotearoa/New Zealand

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Abstract

Amidst growing awareness of neurodiversity, research is scarce on how young Asian women with ADHD experience and navigate their identities within intersecting cultural, gendered, and neurodivergent frameworks. This research explores the lived experiences of neurodivergent (ADHD) young Asian women in Aotearoa/New Zealand. This study addresses a significant gap in the existing literature on neurodivergent Asian women in this context by using a qualitative, Interpretative Phenomenological Analysis (IPA) approach. Semi-structured interviews were conducted with six purposively sampled participants aged 18-25, who were all diagnosed as adults. Five overarching themes, with 14 subthemes, are revealed by the analysis, shedding light on the individuals' evolving perspectives of themselves, their experiences with neurodivergence, and their cultural placement. These themes include the negotiation of neurodivergence in familial and cultural contexts, post-diagnosis identity reconstruction, family and cultural dynamics, and pathways to self-understanding. In addition, the analysis highlights the concerns regarding representation, identity, and isolation, underscoring the difficulties and possibilities for enhancing public discourse about ADHD and fostering a sense of community. The findings reveal a complex and frequently contradictory process of identity reformulation and self-discovery, influenced by several interrelated factors, including cultural expectations and gendered norms. Theoretically, this study advances our understanding of how culture, identity, and neurodivergence interact, thereby helping us better comprehend how participants construct meaning.

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This thesis is dedicated to the ADHD community in Aotearoa/New Zealand. Whether you are very similar to or very different from the participants of this study, formally diagnosed, navigating the diagnostic process, or simply finding the courage to seek answers, I see you, and I wish you all the best on your journey.

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Chapter 1: Introduction

The broad aim of this research was to explore the lived experiences of young adult Asian women in Aotearoa/New Zealand with Attention-Deficit/Hyperactivity Disorder (ADHD). This chapter therefore begins with an overview of ADHD, including its definition in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) and the shortcomings of the diagnostic frameworks in use today, especially their inability to take cultural context, gendered manifestations of ADHD, and emotional dysregulation into consideration. The chapter also highlights the underdiagnosis of ADHD in women, differences in diagnosis between ethnic groups, and the shortcomings of previous studies that only used samples of Caucasian men. In order to put the particular difficulties faced by Asian women with ADHD in perspective, cultural viewpoints, stigma, identity, and conceptualisations of mental health among diverse Asian cultures are also covered. This chapter concludes by highlighting the more specific aims and the rational for this study.

1.1 Background

According to the DSM-5, ADHD is a neurodevelopmental behavioural syndrome characterised by a set of symptoms involving inattention and/or impulsivity or hyperactivity, which can impair an individual's social, academic, or occupational functioning (American Psychological Association; APA, 2018). Because it ignores emotional dysregulation, cognition, gender, hormones, ADHD in old age, ADHD during menopause, and the impact of ADHD on a developing personality, the diagnostic definition in the DSM is both severely inadequate and incomplete (Dodson, 2025).

In the clinical depiction of ADHD, there are three sub-types: Combined presentation, predominantly inattention presentation, and predominantly hyperactive/impulsive presentation (American Psychiatric Association, 2013). By oversimplifying ADHD as either Hyperactive/Impulsive, Inattentive, or Combined types, a significant number of people (up to 30 – 40%) who do not fit these standardised sub-types may be overlooked (Hattatoglu & Mustafa, 2014). As a result, they might miss out on available ADHD resources and receive inadequate care, often being misdiagnosed with Emotional or Behavioural Disturbances or other conditions (Hattatoglu & Mustafa, 2014). Hattatoglu and Mustafa (2014) suggest that

perhaps the key to grasping the total spectrum considered ADHD and providing compassionate care for people who are challenged by the impact is to be open-minded regarding its subtypes, including the Emotional Dysregulation type.

The nationwide incidence of ADHD diagnoses in the United States in children varies by race, though data on this topic is scarce (Shi et al., 2021). In a retrospective cohort study conducted by Shi et al. (2021), among 238,011 children, only 15,183 [6.7%] Asian children were diagnosed with ADHD. When compared to Caucasian children, Asian children had the highest probability of not receiving any treatment (odds ratio: 0.54; 95% CI, 0.42–0.70) (Shi et al., 2021). For example, limited samples of Chinese children and adolescents have been included in previous studies (Liu et al., 2018). Leslie (2002) and Singh (2008) highlight that the majority of ADHD cases in the United States are diagnosed by general practitioners, particularly primary-care physicians, which has been identified as a factor contributing to concerns of overdiagnosis in the general population. At the same time, research has shown that Asian children are significantly less likely to receive a diagnosis or treatment for ADHD compared to their Western peers (Shi et al., 2021). These patterns suggest that while diagnostic practices in the U.S. may inflate overall prevalence rates, important disparities persist, with Asian populations facing underdiagnosis and reduced access to treatment. The following chapter will provide a brief review of the literature surrounding assessment and diagnostic procedures in Aotearoa/New Zealand in comparison to other Western countries.

The estimated prevalence of adult ADHD is less than two times higher in males than in women (5.4% versus 3.2%, respectively); however, women are typically diagnosed with ADHD later in life than men (Grevet et al., 2006; Kessler et al., 2006) due to different symptom presentation, co-occurring conditions, masked symptoms, bias, and hormonal factors (Attoe & Climie, 2023; Children and Adults with Attention-Deficit/Hyperactivity Disorder, 2022; Mental Health Foundation of New Zealand, 2022; Robbins, 2019). Overall, the prevalence of ADHD in adulthood appears to be more comparable across the sexes than in childhood (Kessler et al., 2006). The ratio of boys to girls with ADHD is approximately 3:1, according to data from community samples (Biederman et al., 1999). Comparatively, the male-to-female gender ratio of adults with ADHD approaches 1:1 (Biederman et al., 1994; Kessler et al., 2006). This suggests that girls may be underdiagnosed with ADHD and/or that they are more likely than boys to exhibit the inattentive presentation of ADHD, which tends to last longer during development (Hart et al., 1995; Hinshaw et al., 2012). Additionally, a

four-decade longitudinal study in Dunedin, New Zealand, found that although individuals with childhood ADHD tended to outgrow the complete diagnosis with fewer symptoms, they still faced difficulties adjusting to life well into adulthood (Moffitt et al., 2015). To increase our understanding and ensure that ADHD is diagnosed and treated fairly in all communities, further research and public awareness are necessary.

Due to the primary focus of ADHD on boys and men, specifically of Caucasian descent, little is known about how ADHD affects women from other ethnic backgrounds (Waite & Tran, 2010). Quinn (2008) notes that women make up a more significant percentage of adults with ADHD than has previously been acknowledged, notwithstanding the lack of accurate data on the actual male-to-female ratio of women with ADHD. The majority of research on adults with ADHD has mostly employed quantitative approaches, mainly featured European American populations, and typically concentrated on boys and men (Barkley et al., 2002; Kessler et al., 2006; Meaux et al., 2006). The growing body of data surrounding males and ADHD highlights the need for further investigation into how ADHD impacts women, especially those from racial or ethnic minority backgrounds.

1.1.1 Stigma, Identity, & Sociocultural Perceptions of Mental Health

Determining the obstacles faced by neurodivergent people, especially those from marginalised populations, requires an understanding of how mental health is conceptualised and experienced in various cultural contexts. This section examines the structural and cultural factors that influence how people view mental health, with an emphasis on the ways that institutional and individual stigma interact with societal norms, cultural beliefs, and structural limitations. This section highlights the sociocultural elements that affect help-seeking actions, identity development, and access to care by looking at how ADHD and other psychological illnesses are viewed in both Western and non-Western contexts. In addition to challenging prevailing diagnostic and therapeutic paradigms that could ignore the requirements of neurodivergent Asian women, these insights are crucial for placing their lived experiences in context.

Four types of stigmas have been identified to be associated with mental health: (1) label avoidance, (2) self-stigma, (3) public stigma, and (4) structural stigma (Jones & Corrigan, 2014). The term ‘stigma’ is used to mean a ‘mark of disgrace or infamy’

concerning attitudes and perceptions of self or others (Ng, 1997). Regarding the stigma associated with mental health, Fabrega (1991) described the various labels associated with mental health in contemporary Western society. The appearance of disorders, how they are perceived symbolically, and how they affect a person's identity, social functioning, and capacity for social interaction all contribute to stigmatisation (Ng, 1997).

When an individual refuses to seek mental health treatment to avoid being classified or stereotyped, this is known as label avoidance (Kaur, 2023). For example, parents with kids who have ADHD could be afraid of others knowing their child has been diagnosed, so they may avoid disclosing their struggles or asking for the educational accommodations they need. A worse prognosis, increased morbidity, and increasing functional and interpersonal degradation may result from the child's ongoing avoidance of and disengagement from services (Jones & Corrigan, 2014). When an individual recognises, embraces, and uses a negative stereotype about oneself, self-stigma can occur (Jones & Corrigan, 2014). An individual's entire self-concept may suffer as a result of internalising unfavourable stereotypes, which may include a decline in ambition, self-worth, and success (Kaur, 2023). Personal awareness of negative stereotypes can have a detrimental effect on long-term motivation for significant life objectives by lowering perceived competence in academic and professional performance (Jones & Corrigan, 2014). When the broader public acts discriminatorily and supports unfavourable preconceptions connected to mental health, public stigma arises (Kaur, 2023). By restricting social connections, housing alternatives, career prospects, and healthcare resources, the general public may try to avoid people with mental illness (Corrigan & Kosyluk, 2014). Lastly, institutional discrimination, as shown in public and private laws, policies, and regulations, is referred to as structural stigma (Jones & Corrigan, 2014). To maintain the status quo, the institutional structures frequently disfavour and exclude people with mental illnesses as a result of these stigmatising policies and practices (Kaur, 2023).

Fabrega (1991) discovered many common aspects of psychological stigma by examining the significant traditions of non-Western societies, such as Chinese, Indian, and Islamic:

(1) Every disorder is treated using a somatopsychic or integrated psychosomatic approach. The Western prejudice concerning mental health disorders "being

psychiatric" or having symptoms originating from the psyche is not seen since mental disorders are not isolated from physical disorders.

(2) However, there is a propensity to medicalised insanity, which primarily relates to severe behavioural abnormalities and psychological disorders. Neuroses and other highly somatised mental health disorders are treated like common medical illnesses.

(3) There are additional approaches to illness and behaviour that are supernatural, religious, moralistic, and magical. While they may carry a heavy stigma in certain cultures, they may not in others (for example, the patient may not be held accountable for an external factor, and the treatment may be expected to be brief).

(4) Conditions that are recurrent, chronic, and permanent are prone to be stigmatised. These are considered the product of social and moral offences, genetic and constitutional deficiencies, sorcery, and spiritual punishment.

To identify cultural parallels and contrasts, reassess our knowledge of mental health disorders, and develop treatment plans, cross-cultural comparisons of attitudes towards mental health are crucial (Lin et al., 1995). However, investigating the lived experiences of people from various cultural, social, and economic backgrounds is just as important as examining clinical or societal opinions. This method can offer a more sophisticated comprehension of how mental health disorders, such as ADHD, appear and are managed in diverse settings.

Experiences in daily life demonstrate how societal standards, family structures, educational systems, and professional expectations influence people's difficulties and coping mechanisms (Kapp, 2020). For instance, if ADHD characteristics like impulsivity or hyperactivity fit with cultural values like creativity or expressiveness, they might not be as stigmatised in different cultures. On the other hand, the same characteristics can be viewed as disruptive in cultures with strict standards for behaviour and conduct, which would make people with ADHD feel even more isolated or inadequate (Sengul, 2019). However, whether or not qualities like creativity or an entrepreneurial spirit, which are frequently linked to ADHD, are appreciated frequently relies on the larger social or cultural context, namely how much it encourages or discourages neurodivergent thought patterns. For instance, systems that encourage creativity and permit adaptable, non-linear thinking often foster an environment where these qualities are valued. The difficulties faced by individuals with ADHD or similar neurodivergent profiles, on the other hand, may be exacerbated by strict

systems that place emphasis on compliance and penalise divergence from norms (Armstrong, 2015; Goldberg, 2023). Therefore, it emphasises how crucial it is to address systematic constraints that affect how characteristics are viewed and encouraged in a particular setting, in addition to comprehending cultural values.

Researchers and clinicians can learn more about how intersecting characteristics like race, gender, socioeconomic status and resource accessibility affect mental health by concentrating on these lived experiences. According to phenomenology, it is essential to comprehend how individuals perceive and understand their realities, which are founded on their subjective experiences (Smith et al., 2009). This approach emphasises the significance of considering how people experience their lives in relation to their relationships, environments, and societal norms to better comprehend mental health. This more comprehensive viewpoint makes it possible to create inclusive, culturally aware support programmes that respect the variety of human experiences while removing structural obstacles to mental health. Combining personal stories with cross-cultural perspectives enhances our understanding and fosters a more empathetic, adaptable approach to mental health (Molander et al., 2024).

Lauber and Rössler (2007) evaluated the stigma associated with mental illness in Asia's developing nations. The results are summed up as follows: (1) Asians with mental illness were viewed as dangerous and aggressive; (2) lacked the financial and personal resources to deal with stigma; (3) somatic symptoms were more socially acceptable than psychiatric symptoms; (4) family members were stigmatised; and (5) the role of supernatural and religious approaches to psychiatric illness was prevalent (Lauber & Rössler, 2007). More than a decade later, there is a need for up-to-date research into stigma and methods that can successfully lessen stigma in certain Asian cultures. This further highlights the significance of this research, which explores the lived experiences of neurodivergent Asian women.

A key concept in developmental psychology is identity, which refers to an individual's sense of self as influenced by their experiences, roles, interpersonal connections, and cultural surroundings (Kroger, 2007). Identity formation is a crucial developmental task during adolescence and early adulthood, according to Erik Erikson's (1968) psychosocial theory. The stage of 'identity vs. role confusion' denotes a time when people investigate and integrate different facets of themselves in order to create a cohesive identity (Erikson, 1968). This process was further explained by James Marcia (1980), who described four identity

statuses dependent on an individual's level of investigation and commitment: diffusion, foreclosure, moratorium, and achievement. Navigating expectations surrounding gender roles, job goals, family duties, and developing autonomy are all common aspects of identity formation for young adult women. While identity confusion or conflict can lead to anxiety, despair, and a diminished sense of agency, a strong, cohesive identity is linked to good psychological outcomes including resilience, life satisfaction, and self-esteem.

The cultural setting has a significant impact on the identity building process. Identity development in Western nations is usually centred on individualism, emphasising self-expression, personal liberty, and pursuing personal objectives (Arnett, 2000). On the other hand, collectivism is valued more in many Asian cultures, where identity is more relational and shaped by social and familial roles (Markus & Kitayama, 1991). In diaspora settings such as Aotearoa/New Zealand, young Asian women frequently handle a difficult nexus of various cultural frameworks, striking a balance between familial demands of responsibility, obedience, and cultural legacy preservation and Western ideals of independence. As a result of Western health concepts not being in line with intergenerational or cultural standards, this duality can lead to distinct identity difficulties, especially when it comes to mental health and self-concept. Since unresolved friction between cultural expectations and personal identification can impede good life outcomes and contribute to internalised stigma or psychological discomfort, it is imperative that these parts of identity be successfully integrated for well-being.

1.1.2 Perspectives of Mental Health Among Various Asian Cultures

In non-Western societies, somatisation surrounding mental health has been extensively documented in literature. However, this is not a culturally unique phenomenon, as it is also prevalent in the West. A number of these theories have been suggested, including affect denial and suppression, a lack of emotional lexicon, the impact of conventional medicine, avoiding social stigma, social learning and expectations, and a lack of mind-body difference (Ng, 1997).

Chinese medicine, founded on the concept of *Tao* (道) and adopting a functional approach, focuses on restoring balance under the principles of yin-yang, the five evolutionary phases, *Ching-Lo*, and the chi orientation (meridian system) (Lin, 1981). Chinese archives

indicate that in the past, those with mental health disorders were treated with a fair amount of compassion (Tseng, 1973). Nonetheless, there is evidence that those with disorders were treated with anything from sympathy and understanding to harsh incarceration (Ng, 1997). Chinese perspectives on the aetiology of mental health are complex (Lin & Lin, 1981). It can be seen as moral transgressions against social standards or ancestral values, for which the family is also held accountable (Ng, 1997). Alternatively, it may be related to a hereditary or even ancestral inheritance of wrongdoing, in which case the individual, and in some cases, their siblings may be barred from marriage (Ng, 1997). Strong mental stigma is most likely associated with the family due to the heavy burdens of acute guilt and shame they bear. Having mental health problems is known to tarnish family honour, name, and ancestors. A portion of the stigma around mental health stems from the concern that Chinese families may reveal their shame to others and lose face. The greater the need to hide its 'disgrace' from being shown, the more severe the stigma associated with mental health (Lin & Lin, 1981).

Given Japan's East Asian cultural heritage, some of its views and practices about mental health are comparable to those of the Chinese. Somatic expressions of psychological discomfort are common, and they are frequently misdiagnosed (Munakata, 1986). The widespread perception that mental health disorders are inherited and constitutional results in significant stigmatisation because purity is greatly valued (Ng, 1997). The "shame culture" in Japan is also deeply ingrained with a need for social acceptance, which contributes to the family's need to distance itself from mental disorders. Patients are, therefore, discouraged from re-entering society (Samuma, 1978).

South-East Asian cultures share similarities with those in East Asia in terms of attitudes, family responses, and approaches to mental health. The Vietnamese see mental disorders as 'crazy' and believe they are incurable (Do et al., 2018; Lien & Rice, 1992; Lien, 1993). The substantial stigma associated with mental health patients and their families is reflected in the fear of one's mental health issues being revealed to others and the hiding of distress. Even in cases where psychiatric treatment is advantageous, denial makes individuals reluctant to accept it. Additionally, Vietnamese view accepting treatment as a sign of weakness in one's character, fortitude, and dignity.

According to Way (1985), the absence of contemporary ideas about mental health, the seclusion of mental hospitals, and the prejudice of medical professionals towards those with disorders are among the obstacles to the Burmese community's acceptance of mental health

programmes. Families seek assistance from Buddhist priests, indigenous leaders, witch doctors, and ritual practices due to the traditional beliefs stemming from Buddhism and the Nat cult (animistic beliefs) (Ng, 1997).

Westermeyer (1979) investigated rural Lao people's folk conceptions of mental health disorders. Aetiologies that place blame on the afflicted are met with rejection, whereas aetiologies that are unclear elicit greater community acceptance (Westermeyer, 1979). Additionally, Westermeyer (1979) noted that belief systems are adaptable enough to incorporate various therapeutic approaches.

Mental health difficulties in Malaysian culture have also been described and linked to supernatural causes, including consequences for previous transgressions (Ng, 1997). Psychiatry is also strongly stigmatised, especially among medical professionals (Ng, 1997). Nonetheless, according to Ng (1997), Malays are generally the most accepting and less judgmental of the three major ethnic groups: Malay, Chinese, and Indian.

In Singapore, one of the leading causes of suicide is thought to be society's unfavourable and insensitive views towards those with mental health disorders (Tsoi & Kok, 1995). According to Teo (1978), 70% of patients admitted for the first time to a significant psychiatric hospital in Singapore for mental illness had previously sought advice from alternative "healers." Presentation of mental health issues is often, therefore, delayed when the family is in denial, and those who face mental health issues typically steer clear of psychiatric services out of concern for being stigmatised (Ng, 1997).

The folk and Ayurvedic, or Indian traditional medicine, traditions have a significant influence on the notions of *unmada,* or severe mental disorders, in Indian society (Weiss et al., 1986). While the Ayurvedic tradition discusses mental health disorders in terms of humoral imbalance, folk traditions emphasise supernatural factors (Ng, 1997). Additional native beliefs that are employed include astrology, karma, physical illnesses, and extreme stressors (Ng, 1997). According to Waxler (1974), psychological stigma is uncommon in Sri Lanka, where Sinhalese Buddhists predominate rather than Tamil Hindus. It is believed that severe mental disorders are temporary and treatable; the individual's identity and credibility remain unchanged, and they are not held accountable for their disorder (Waxler, 1974).

As the literature highlights, stigma is simply one aspect of the lack of acceptance of mental health disorders and psychiatric treatment in many Asian societies. It does not address the significant difficulties when stigma is indiscriminately and arbitrarily blamed for mental

health care problems. Examining Asian conceptions, experiences, and consequences of psychological issues, as well as the sociocultural reaction to mental health, can be more pertinent. The use of mental health services, treatment compliance, treatment response, preventative programmes, and public education tactics would all be directly impacted by this knowledge. Notably, the literature reviewed in this section is dated, as the literature exploring modern outlooks on mental health across Asian cultures is scarce. Given that many parents of young Asian women in Aotearoa/New Zealand are likely to have grown up in circumstances influenced by these earlier cultural attitudes, this emphasises the importance of the current research. As a result, stigmas like these could still have an impact on family interactions and common misconceptions about mental health and neurodivergence, especially when it comes to receiving support, receiving a diagnosis, and forming an identity.

1.1.3 Perspectives of ADHD Among Various Asian Cultures

This section explores ADHD among various Asian cultures, where ADHD is predominately presented as a weakness or disability. I want to emphasise that I am not researching with bias from my own lived experience and that due to widespread stigma among Asian cultures, it is challenging to source literature that explores the positives of ADHD – a theme mainly explored in Western settings.

Confucius (551 – 479 BC), a Chinese philosopher, left behind a body of work known as Confucianism that focused on human morality and appropriate behaviour. Confucianism has had a profound influence on East Asian cultures, particularly in China, Singapore, Taiwan, Japan, Korea, and Vietnam (Moon, 2012). Any delinquent behaviour that disturbs the peace is seen as ‘non-moral’, and both the individual and the group or family they belong to should feel shame (Moon, 2012). In the 1970s, ADHD was initially identified and researched in East Asia, coinciding with the first diagnoses in the West (Gueorguieva, 2015). While certain East Asian countries continue to adhere to their long-standing cultural and social traditions, modern Western influences have permeated these cultures, impacting daily life. The globalisation of the condition and the rise in ADHD diagnoses may have been influenced by this cultural Westernisation (Gueorguieva, 2015).

Notwithstanding widespread Westernisation, the environmental circumstances in East Asia do not align with the Western lifestyle, and the Chinese social structure differs from

Western family and societal structures (Conrad & Bergey, 2014). However, traditional cultural beliefs still play a significant role in modern East Asian communities, which remain only partially receptive to Western customs. As a result of this cultural disparity, the current international diagnostic criteria for ADHD may seem both comprehensive and inadequate. For example, the 'one size fits all' method of assessing ADHD is one of the main issues with diagnosing the disorder across different cultures (Timimi & Maitra, 2009).

India offers an intriguing example of how parents, as well as doctors and educators, have both enthusiastically embraced and vigorously contested the idea of ADHD and the medication that goes along with it (Smith, 2017). For example, the case of ADHD in India offers more evidence that societal factors – more specifically, class and socioeconomic concerns – have influenced perceptions and acceptance of ADHD (Smith, 2017). However, parents' readiness to embrace an ADHD diagnosis in the hopes that it will enable their children to reach their full potential has been an overlooked motive in India (Smith, 2017). It seems that there are a variety of complex reasons why parents have accepted, rejected, or tolerated an ADHD diagnosis in India.

Unlike Indian psychiatrists, Chinese psychiatrists have understood for decades that hyperactivity is common in children (Shen et al., 1985; Xin et al., 1981). In public spaces like parks, children were reserved but not scared, content to have fun as long as they did not bother adults. Strong, multigenerational family groupings also meant that family elders resolved many emotional issues raised by youngsters to the point where family members risked losing face if they could not handle it (Smith, 2017). As a result of changing societal attitudes brought forth by media representations, Chinese families became more receptive to receiving a diagnosis of ADHD. Kuo-Tai Tao, a psychiatrist from Nanjing, claims that a popular magazine's depiction of ADHD in the mid-1980s caused a spike in diagnoses, with many people believing it to reflect parents' 'overconcern' for their 'only child' and their academic achievement (Tao, 1992). China presents an intriguing case for ADHD, with all the characteristics of a complex society moulded by long-standing customs, sixty-five years of communism, and sporadic encounters with the West.

The literature on the perspectives of ADHD among various Asian cultures has allowed us to make better sense of the circumstances in which Asian immigrant parents grew up. Consequently, this causes a continuum of stigmatising beliefs and familial shame, instilling them in the newer generations. More recent research is required to measure whether

perspectives have shifted as Asian people have migrated all over the world to settings where diagnoses of ADHD are more widely accepted. This research will also help us understand whether the generational stigma in Asian culture has impacted the identity of younger generations.

1.1.4 Gender & ADHD

Previously believed to be a male-dominant neurodevelopmental disorder, research has now shown that ADHD affects women as well. Faheem et al.'s (2022) comprehensive systematic review provides enough evidence of gender variations in adult ADHD prevalence effects to rule out gender-to-gender similarities. Not only is it crucial to comprehend the relationship between gender and ADHD from a theoretical and research standpoint, but it also helps clinicians better grasp the experiences of individuals with ADHD. Gender is a fundamental component of identity that affects various aspects of functioning, including academic, professional, interpersonal, and physical performance (Hyde, 2014).

Despite ADHD being regarded as one of the most well-researched childhood disorders (Arnold, 1996; Barkley, 1998), most research on the disorder has tended to concentrate on a relatively homogenous sample of participants: Caucasian males who have been clinically referred. The small sample size severely limits the ability of ADHD researchers to extrapolate results to women and the broad community (Gershon, 2002). Furthermore, the identification and treatment of females with ADHD have been hampered by the paucity of lived experience research giving voice to this population (Young et al., 2020).

Many males and females should fit the criteria for ADHD based on research of community samples. However, clinical investigations hardly ever identify females. Since social, academic, and emotional challenges are among the long-term issues associated with ADHD, this paucity of knowledge about females with the disorder could have significant public health repercussions (Arnold, 1996; McGee & Feehan, 1991). Due to their expression of ADHD characteristics, females with ADHD constitute a 'silent minority' (Berry et al., 1985). Specifically, females with ADHD are more likely to be ignored if they exhibit inattentive behaviours (Gaub & Carlson, 1997) since they exhibit less disruptive behaviour than males with ADHD (Achenbach, 1991). In order to fit in with society and prevent stigma, many women with ADHD engage in masking behaviours, purposefully or unintentionally

hiding their symptoms (Quinn & Madhoo, 2014). These masking techniques, which frequently result in underdiagnosis or misdiagnosis, can include internalising discomfort, social imitation, and overcompensating through perfectionism (Wicherkiewicz & Gambin, 2024). Gendered expectations, which teach girls and women to be obedient, well-organized, and emotionally controlled, contribute to this inclination to hide, making activities associated with ADHD seem less disruptive or obvious (Young et al., 2020). According to Arnett et al. (2015), many women claim that they were mislabelled with anxiety or mood disorders or struggled in silence for years before finally receiving a diagnosis as adults. Disseminating knowledge about the gender disparities in ADHD is essential for recognising the symptoms of ADHD.

1.2 Significance of the Research: Rationale & Aims

This research is essential because it is one of the few that concentrates on neurodivergent Asian women. By centring lived experiences, it highlights the distinct challenges and perspectives that emerge at the intersection of these identities. Intersectional research, which explores how gender, race, class, and ethnicity interact to shape neurodivergent experiences, is increasingly necessary (Acosta, 2023; Bergey et al., 2022). Such approaches advance academic knowledge by offering a more comprehensive understanding of mental health inequalities and the complex ways ADHD is experienced, perceived, and diagnosed across different populations. In doing so, this research contributes to diversifying academic discourse and challenging prevailing stereotypes.

One of the ethnic groups in Aotearoa/New Zealand with the quickest rate of growth is the Asian population, which is concentrated in major cities like Auckland (Stats NZ, 2019). The 2018 New Zealand Census revealed that more than 77% of Asians were not born in Aotearoa/New Zealand, underscoring the group's high rate of first-generation immigrants (Stats NZ, 2019). Given that this study focuses on the lived experiences of first-generation Asian women with ADHD, this demographic background is very pertinent. Addressing the particular difficulties this community may encounter in the family, educational, and healthcare systems requires an understanding of how cultural background, migration, and neurodivergence connect.

The lack of representation of neurodivergent Asian women in academic literature, especially in the setting of Aotearoa/New Zealand, is the key rationale behind this study. The majority of research still focuses on Western, male-centric populations, despite ADHD becoming more widely recognised in adults and among women. As was previously said, how Asian populations view, feel, and manage ADHD can be greatly influenced by cultural stigma, intergenerational expectations, migration histories, and acculturation processes. However, little is known about the ways in which these factors interact in the lives of young Asian women in Aotearoa/New Zealand who are dealing with ADHD. In order to better understand the interactions between cultural identity, gender, and neurodivergence, this study aimed to investigate the lived experiences of this underrepresented population. Broad enquiries about how participants interpret their diagnoses, how their cultural and familial backgrounds influence this interpretation, and how they adjust their identities in response served as its compass. In doing so, this study may help schools, support services, and healthcare professionals create more inclusive, person-centred, and culturally sensitive methods of assessing and treating ADHD.

Moreover, this study contributes to intersectional research on young women with ADHD from diverse cultural backgrounds by addressing the practical implications of these findings. It highlights the complex interplay of social, cultural, and personal factors that shape how neurodivergent identities are understood and managed. Specifically, it examines how first-generation Asian women in Aotearoa/New Zealand make sense of their ADHD diagnoses in relation to their gender, cultural identity, and well-being. By drawing attention to this underrepresented group, the study not only broadens representation but also supports efforts to inform inclusive policy, culturally responsive healthcare, and community-based support networks.

Chapter 2: Literature Review

This chapter provides a comprehensive analysis of Attention Deficit/Hyperactivity Disorder (ADHD), beginning with the prevailing clinical perspectives and diagnostic standards and then exploring new insights informed by the neurodiversity paradigm. The chapter also discusses gendered and cultural differences in symptom presentation, examines how ADHD is diagnosed and treated in Aotearoa/New Zealand and draws attention to the shortcomings of current diagnostic frameworks. This literature review establishes the foundation for investigating how young Asian women in Aotearoa/New Zealand cope with their ADHD diagnosis and its consequences for identity, culture, and wellness by placing the disorder in both local and global contexts.

There was a lack of empirical research that specifically addressed the experiences of Asian women with ADHD in Western contexts, despite a thorough search across the Google Scholar database using a combination of keywords such as ADHD, Asian women, first-generation, Western countries, and lived experiences. Only a few tangential studies that were either gender nonspecific, child-focused, or did not centre lived experience were found despite the search's investigation of grey literature, theses, and cross-cultural mental health journals. This noteworthy omission from the literature draws attention to a crucial and widespread lack of knowledge in academia and clinical practice about the intersections of gender, neurodivergence, and cultural identity for this population. The current study aims to start addressing this gap by elevating the voices and lived experiences of first-generation Asian women with ADHD in Aotearoa/New Zealand.

2.1 Attention Deficit/Hyperactivity Disorder (ADHD)

From a clinical perspective, ADHD stands for Attention Deficit/Hyperactivity Disorder. However, it is not an attentional deficit if the individual engages with tasks they enjoy or are passionate about (Barkley, 1997). Individuals with ADHD can hyperfocus, in which case attention is not a deficit but present in greater intensity than it is for neurotypical individuals. As such, there is an argument to be made that ADHD could be better understood as an attentional and hyperactivity difference, with fewer environments supporting these differences (e.g., educational, familial, social), making it both challenging and rewarding (Doyle, 2020). ADHD has long been presented as a weakness in Western medicalised

traditions, with impulsivity, hyperactivity and concentration problems as its hallmarks. According to this perspective, which has its roots in the medical model, ADHD is a psychopathology – an issue that interferes with everyday functioning and necessitates medical treatment (American Psychiatric Association, 2013; Barkley, 2015). People with ADHD are frequently portrayed as patients who have an innate defect or dysfunction as a result of this framing, which often results in overly clinical depictions (Jones & Orchard, 2024). This deficit-based viewpoint is called into question, nevertheless, by the emergence of the neurodiversity paradigm and the social model of disability (Kapp et al., 2013; Singer, 1999).

Neurodiversity advocates contend that ADHD is a neurological uniqueness that presents particular strengths and challenges rather than just a condition (Armstrong, 2015). According to this paradigm, challenges often arise from the mismatch between neurodivergent features and rigid societal standards rather than the disorder itself. For example, a Western psychologist with ADHD may recognise the creativity, energy, and problem-solving abilities their brain may provide. Still, they may also view themselves as someone navigating a world intended for neurotypical people rather than as a 'patient' with psychopathology (Goldberg, 2023). This changing viewpoint signifies a departure from medicalised deficiency models and a move towards a more holistic understanding of ADHD that embraces variety while removing obstacles. It emphasises how crucial it is to change attitudes and surroundings to become more accepting, creating a society in which people who are neurodivergent can flourish.

In Aotearoa/New Zealand, a general practitioner or counsellor can raise concerns about ADHD symptoms in a referral to a specialist, such as a psychologist or psychiatrist, who can then formally assess and diagnose the individual. During an assessment, the specialist typically examines the individual's medical history and overall mental health, including their mood and any underlying medical issues. They then discuss the individual's past behaviour and educational experiences, as well as their present behaviour if they are adults (American Psychiatric Association, 2013; Young & Gudjonsson, 2008). To learn about behaviours and experiences at home, school, or elsewhere, the specialist may need to speak with the individual's family, friends, partners, teachers, and other people who know them well and have observed them in various contexts. Most commonly, the specialist will request to review copies of the individual's primary and secondary school reports or speak

with a parent or legal guardian. A standardised behaviour rating scale (e.g., Adult ADHD Self-Report Scale, Conners Rating Scale, Vanderbilt Assessment Scale) is used to determine if the individual meets the criteria for an ADHD diagnosis. The specialist may also conduct psychological assessments that examine cognitive capabilities, including reasoning, executive functioning (which encompasses planning and decision-making), working memory, and visual and spatial abilities. These assessments can help detect or rule out potential learning difficulties, as well as identify psychological or cognitive strengths and weaknesses.

ADHD has no known cure, although modern therapies may help lessen symptoms and enhance functioning. Psychotherapy, medication, and other behavioural therapies are common treatments for ADHD (Barkley, 2015; National Institute of Mental Health, 2024). Parent education and school-based initiatives are frequently a part of treatment for children. The most widely prescribed drug for ADHD is a stimulant, which studies have shown to be highly effective – improving symptoms in approximately 70% of adults and 70 – 80% of children (Advokat & Scheithauer, 2013). Stimulant drugs function by increasing the levels of dopamine and norepinephrine in the brain – the neurotransmitters that affect attention and concentration – therefore improving prefrontal cortex function and increasing a person's attention and concentration (Arnsten & Pliszka, 2011). There are numerous types of psychological treatments for ADHD that can be used in conjunction with medication and other components for teachers, parents, and families (e.g., behavioural therapy, cognitive behavioural therapy, family and marital therapy). Incorporating therapy into an ADHD treatment plan can help individuals manage hazardous and impulsive behaviours, improve confidence, and cope better with daily challenges. When ADHD is comorbid with other mental disorders, such as anxiety, depression, conduct issues, or substance use disorders, therapy can be especially beneficial (Barkey, 2015). In addition to medication and psychotherapy, those with ADHD can be aided with parent education and support, school-based programs, cognitive training, neurofeedback, or complementary health approaches (National Institute of Mental Health, 2024).

Continued research regarding adults with ADHD can help secure the foundations of effective diagnosis and treatment. By exploring the lived experiences of adult Asian women with ADHD, we can highlight the processes taken to receive a diagnosis, whether cultural or identity barriers were present, and whether the diagnostic process and treatment in Aotearoa/New Zealand are proven to be efficient and gender – and culturally inclusive.

2.1.1 The Diagnostic and Statistical Manual of Mental Disorders (5th ed.) (DSM-5) and the *International Classification of Diseases (11th ed.) (ICD-11)*

According to the DSM-5, there are three ADHD subtypes that an individual can be diagnosed with, depending on their specific symptoms: Combined presentation, predominantly inattention presentation, and predominantly hyperactive/impulsive presentation (American Psychiatric Association, 2013). The symptoms must begin in childhood (before age 12) and may continue into adolescence and adulthood. Due to this early onset requirement, a thorough developmental history is frequently included in the assessment process, as mentioned previously. The diagnostic criterion slightly differs based on age: Children up to 16 years old must show at least six symptoms of inattention, hyperactivity and impulsivity, or both, and adults and youth over 16 years old must show at least five symptoms of inattention, hyperactivity and impulsivity, or both. In addition, the symptoms must also occur for at least six months, be present in two or more settings (e.g., home, work, school), and interfere with or impair social, school, or work functioning. However, health professionals must thoroughly evaluate individuals to determine that other physical conditions with similar symptoms, such as stress, sleep disorders, anxiety, and more, do not cause their symptoms.

Despite the clinical guidelines in the DSM-5, ADHD does not present itself the same in everyone. The presentation of symptoms has been shown to vary depending on age, gender, and culture (Mowlem et al., 2019; Ghoshal, 2022). Boys and men tend to display more hyperactive and impulsive symptoms, while girls and women are more likely to be diagnosed with inattentive ADHD (National Institute of Mental Health, 2024). While symptoms must be present before the age of 12, ADHD can be diagnosed at any age. The symptoms of ADHD may also change as a person ages (National Institute of Mental Health , 2024). For example, hyperactivity and impulsivity are the most common symptoms shown in children. During childhood, the symptoms of inattention often become more noticeable and start to impact peer relationships and academic achievement as social and educational demands increase (National Institute of Mental Health , 2024). Adolescents tend to show less hyperactivity and may appear increasingly restless or fidgety. Impulsivity and inattention symptoms usually persist and might lead to problems in relationships, organisation, or

academics. Risky, impulsive behaviours, including substance abuse and unsafe sexual engagement, are more common among teenagers with ADHD as a result of poor executive functioning and difficulties with self-regulation (National Institute of Mental Health , 2024; Rooney, 2025; Sarver et al., 2014). Lastly, inattention, restlessness, and impulsivity are common in adults with ADHD. However, the symptoms can become less severe and less disruptive for some. Additionally, adults with ADHD can be easily agitated, have a poor threshold for stress and frustration, or have abrupt or severe mood swings (National Institute of Mental Health , 2024).

Figure 1

DSM-5 Diagnostic Criteria for ADHD

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterised by (1) and/or (2):
   1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
      Note: the symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.
      a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
      b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
      c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
      d. 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).
      e. Often has difficulty organising tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganised work; has poor time management; fails to meet deadlines).
      f. 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).
      g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
      h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).
      i. Is often forgetful and daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).
   2. Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:
      Note: The symptoms are not solely a manifestation of oppositional behaviour, defiance, hostility, or a failure to understand tasks or instructions. For older adolescents and adults (aged 17 and older), at least five symptoms are required.
      a. Often fidgets with or taps hands or feet or squirms in seat.
      b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in situations that require remaining in place).
      c. Often runs about or climbs in situations where it is inappropriate. (**Note:** In adolescents or adults, may be limited to feeling restless.)
      d. Often unable to play or engage in leisure activities quietly.

e. If often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
f. Often talks excessively.
g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
h. Often has difficulty waiting for his or her turn (e.g., while waiting in line).
i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
E. The symptoms do not occur extensively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal.

Specify whether:

314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

314.01 (Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity/impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

Specify if:

In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.

Moderate: Symptoms or functional impairment between "mild" and "severe" are present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

For mental disorders, the DSM-5 is predominantly used by mental health professionals in Aotearoa/New Zealand; however, some countries refer to the International Classification of Diseases (11th ed.) (ICD-11) instead. Both the DSM-5 and the ICD-11 are used to classify and diagnose mental disorders. However, there are some significant distinctions between the two (Psychology Today, n. d.):

(1) The DSM-5 solely addresses mental disorders, but the ICD-11 covers all medical conditions, both psychological and physical.
(2) While the DSM-5 is primarily used in the United States, Canada, Australia and New Zealand, the ICD-11 is used all around the world. In Asia, the ICD-11 is more commonly used in China and Japan, while the DSM is favoured in Korea and Taiwan (Suzuki et al., 2010).
(3) The World Health Organisation creates the ICD-11, and the American Psychiatric Association publishes the DSM-5.
(4) DSM-5 diagnoses are based on criteria, while ICD-11 diagnoses are based on guidelines.
(5) The DSM-5 appropriates ICD-11 codes for DSM-5 diagnoses, while the ICD-11 has diagnostic codes.
(6) The DSM-5 can be purchased as a print or digital manual, while the ICD-11 is freely accessible online.

Researchers, doctors, and the general public's understanding of mental health is influenced by the ICD-11 and the DSM-5. Although the two have a lot in common, over time, several revisions have been made, adding, modifying, or eliminating specific diagnoses. They both evolve, sometimes in tandem and other times separately. One notable change in the ICD-11 was the addition of the diagnosis of ADHD as of January 1, 2022 (World Health Organization, 2022).

Figure 2

ICD-11 Diagnostic Criteria for ADHD

Essential (Required) Features:

- A persistent pattern (e.g., at least 6 months) of inattention symptoms and/or a combination of hyperactivity and impulsivity symptoms that is outside the limits of normal variation expected for age and level of intellectual development. Symptoms vary according to chronological age and disorder severity.

Inattention

- Several symptoms of inattention that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning. Symptoms are typically from the following clusters:
- Difficulty sustaining attention to tasks that do not provide a high level of stimulation or reward or require sustained mental effort; lacking attention to detail; making careless mistakes in school or work assignments; not completing tasks.
- Easily distracted by extraneous stimuli or thoughts not related to the task at hand; often does not seem to listen when spoken to directly; frequently appears to be daydreaming or to have mind elsewhere.
- Loses things; is forgetful in daily activities; has difficulty remembering to complete upcoming daily tasks or activities; difficulty planning, managing and organising schoolwork, tasks and other activities.

Note: Inattention may not be evident when the individual is engaged in activities that provide intense stimulation and frequent rewards.

Hyperactivity impulsivity

- Several symptoms of hyperactivity/impulsivity that are persistent, and sufficiently severe that they have a direct negative impact on academic, occupational, or social functioning. These tend to be most evident in structured situations that require behavioural self-control. Symptoms are typically from the following clusters:
- Excessive motor activity; leaves seat when expected to sit still; often runs about; has difficulty sitting still without fidgeting (younger children); feelings of physical restlessness, a sense of discomfort with being quiet or sitting still (adolescents and adults).
- Difficulty engaging in activities quietly; talks too much.
- Blurts out answers in school, comments at work; difficulty waiting turn in conversation, games, or activities; interrupts or intrudes on others conversations or games.

- A tendency to act in response to immediate stimuli without deliberation or consideration of risks and consequences (E.g., engaging in behaviours with potential for physical injury; impulsive decisions; reckless driving)
- Evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12, though some individuals may first come to clinical attention later in adolescence or as adults, often when demands exceed the individual's capacity to compensate for limitations.
- Manifestations of inattention and/or hyperactivity/impulsivity must be evident across multiple situations or setting (e.g., home, school, work, with friends or relatives), but are likely to vary according to the structure and demands of the setting.
- Symptoms are not better accounted for by another mental disorder (e.g., an Anxiety or Fear-Related Disorder, a Neurocognitive Disorder such as Delirium).
- Symptoms are not due to the effects of a substance (e.g., cocaine) or medication (e.g., bronchodilators, thyroid replacement medication) on the central nervous system, including and withdrawal effects, and are not due to a Disease or the Nervous System.

Specifiers to describe predominant characteristics of clinical presentation:
The characteristics of the current clinical presentation should be described using one of the following specifiers, which are meant to assist in recording the main reason for the current referral or services. Predominance of symptoms refers to the presence of several symptoms of either an inattentive or hyperactive/impulsive nature with few or no symptoms of the other type.

6A05.0 Attention Deficit Hyperactivity Disorder, predominantly inattentive presentation
- All diagnostic requirements for Attention Deficit Hyperactivity Disorder are met and inattentive symptoms predominate.

6A05.1 Attention Deficit Hyperactivity Disorder, predominantly hyperactive-impulsive representation
- All diagnostic requirements for Attention Deficit Hyperactivity Disorder are met and symptoms of hyperactivity-impulsivity predominate.

6A05.2 Attention Deficit Hyperactivity Disorder, combined presentation
- All diagnostic requirements for Attention Deficit Hyperactivity Disorder are met and both hyperactive-impulsive and inattentive symptoms are clinically significant aspects of the current clinical presentation, with neither clearly predominating.

Both the DSM-5 and ICD-11 diagnostic criterion provides crucial context and guidelines for understanding ADHD diagnosis within diverse cultural and clinical settings. The distinct experiences of neurodivergent young Asian women in Aotearoa/New Zealand are better framed when the differences in diagnostic criteria, symptom presentation by age and gender, and the various international applications of these manuals are acknowledged. The ICD-11 is more commonly used in several Asian countries, whereas mental health practitioners in New Zealand primarily utilise the DSM-5 (Suzuki et al., 2010). This research acknowledges ongoing advancements in the classification of ADHD.

2.1.2 Summary of Literature Review

The clinical underpinnings of ADHD have been described in this chapter, along with new criticisms based on the neurodiversity paradigm. Although ADHD has historically been portrayed as a problem that has to be treated, newer viewpoints increasingly see it as a difference that is influenced by and sensitive to social, cultural, and environmental factors (Kapp et al., 2013; Timimi, 2017). Understanding ADHD presents a distinct challenge for young Asian women in Aotearoa/New Zealand due to the intersection of gender norms, cultural expectations, and diagnostic procedures. However, there remains a dearth of qualitative studies examining how members of this group understand and cope with their diagnosis within larger sociocultural contexts. The methodological strategy used in this study, IPA, is described in the next chapter. Its goal is to capture the depth and complexity of the participants' lived experiences and meaning-making processes.

Chapter 3: Methodology

This chapter provides a summary of the study's design, which aims to explore the lived experiences of neurodivergent (ADHD) first-generation young Asian women in Aotearoa/New Zealand. The study aims to fill important gaps in the literature by elevating voices that have frequently been overlooked in both ADHD and cultural research, given the scarcity of studies on this intersectional group. An overview of the research design, including the methodological framework and techniques employed to achieve the research aims, is outlined in this chapter.

3.1 Research Design

The philosophical foundations of hermeneutic phenomenology were employed in this research. For this study, the epistemological stance of hermeneutic phenomenology is most appropriate and valuable (Rosqvist et al., 2020), as it seeks to interpret meaning from lived experiences. This method is especially pertinent for examining the complex, intersectional reality of neurodivergent young Asian women since it recognises that people's experiences are influenced by their social, cultural, and historical backgrounds (Laverty, 2003). Hermeneutic phenomenology acknowledges the researcher's involvement in co-constructing meaning through interpretation rather than seeking objective 'truths' (Laverty, 2003). This enables a deeper understanding of how participants perceive identity, stigma, and belonging to the neurodiversity community and their cultural community. This is crucial for studies that seek to elevate underrepresented perspectives and subvert prevailing Western-centric narratives in the discourse surrounding neurodiversity.

This study utilised an IPA approach to explore the lived experiences of neurodivergent Asian women in Aotearoa/New Zealand. The study's epistemological commitment to understanding how participants navigate culturally situated experiences of neurodivergence to make sense of their identities aligns with IPA. The objectives of narrative inquiry are also in line with IPA's emphasis on interpretative depth and personal meaning-making, especially when it comes to appreciating participants' storytelling as a source of knowledge (Smith et al., 2009). The idiographic and introspective character of IPA provided an excellent framework for recognising the complexity, nuance, and cultural embeddedness of participants' lived circumstances, especially considering the underrepresentation of

neurodivergent Asian voices in previous research (Eatough & Smith, 2017; Smith et al., 2009). IPA was selected as the primary methodological strategy for examining participant experiences within this larger theoretical framework because it seeks to explore in depth how individuals perceive life events and provide a thorough interpretation of the narrative to comprehend the expertise (Smith et al., 2009). IPA belongs to a group of phenomenological psychology approaches that, while differing somewhat in their theoretical commitments and emphases, generally concur on the need for an experiencing viewpoint for the field (Eatough & Smith, 2017). When IPA was first introduced in the UK in the 1990s, it was primarily adopted as a method for studying the psychology of experienced phenomena in clinical and counselling psychology, as well as in health (Eatough & Smith, 2017). Its reach has significantly expanded since then. The approach aligns with the study's objective of exploring individual viewpoints and the complex understanding of how ADHD impacts identity.

Theoretical frameworks such as narrative inquiry offer a critical lens for comprehending the lived experiences of young Asian women with ADHD in Aotearoa/New Zealand, which have influenced this study. Exploring how people create meaning through cultural and personal narratives is possible through narrative inquiry (Lindsay & Schwind, 2016), for example in the context of neurodivergence in Asian populations (Patel et al., 2023). By highlighting possible conflicts between deficit-based conceptions of neurodivergence and traditional Asian values that emphasise academic achievement, discipline, and collectivism, critical disability studies contest the prevalent Western medical model of ADHD (Feng et al., 2024). As it recognises how several overlapping identities – such as gender, ethnicity, and neurodivergence – shape individual experiences of ADHD, including interactions with ableism and cultural stigma, an intersectionality framework is also crucial (Bergey et al., 2022; Funer, 2023). Additionally, this study supports the neurodiversity paradigm, which reinterprets ADHD as a normal variance in cognitive performance that occurs within the human spectrum rather than as a disorder that needs to be 'fixed' (Swanepoel, 2024).

Instead of considering neurodiversity as a disease or deficiency, the neurodiversity paradigm promotes a social and cultural understanding of neurodivergence, challenging the conventional medical concept of neurological differences (Walker & Raymaker, 2021). This paradigm is based on the notion that differences in neurological functioning are expected and

beneficial features of human diversity. Therefore, a neurodiversity paradigm places a strong emphasis on acceptance, self-advocacy, and the acknowledgement of neurodivergent voices as essential components of knowledge creation (Walker & Raymaker, 2021). This entails changing the approach in research from one that pathologises individuals who are defined solely by diagnostic criteria to one that emphasises lived experiences and recognises neurodivergent people as authorities on their realities (Kapp et al., 2013). Adopting a neurodiversity-informed phenomenological research approach for this study guarantees that the viewpoints of participants are included and given priority as primary sources of data, notwithstanding interpretative challenges.

Hermeneutic phenomenology seeks to comprehend lived experiences through participants' meaning-making processes, employing the method of IPA (Smith et al., 2009). Rigour requires the researcher to engage in reflexive participation, ensuring that interpretations remain faithful to participants' stories rather than being influenced by presumptions based on deficits. This study seeks to challenge prevailing stigmatising discourses, elevate the voices of neurodivergent people, and advance a more inclusive and representative understanding of ADHD experiences in Asian communities by putting tenets of the neurodiversity paradigm front and centre.

3.1.1 Phenomenology & Hermeneutic Phenomenology

Edmund Husserl (1859–1938), often referred to as the 'father of phenomenology' (Cohen, 1987; Koch, 1996; Polkinghorne, 1983; Scruton, 2004), initially concentrated on mathematics in his early writings, with his dissertation delving into the calculus of variations. Over time, his focus shifted from mathematics to phenomenology, which he viewed as both objective and subjective before subjectivity finally dominated his work (Cohen, 1987; Reeder, 1987). Husserl's desire to create a solid basis for knowledge production motivated his path from mathematics to phenomenology and objectivity to subjectivity. He concluded that all objectivity is based on subjective experience whilst viewing phenomenology as a rigorous, objective approach (Hartimo, 2021). Husserl's interest in 'pure phenomenology,' or seeking a universal basis for philosophy and science, was the result of this development (Scruton, 2004). The foundation for phenomenology, as a methodological and philosophical approach that emphasises lived experience, was thus established.

Martin Heidegger (1889 – 1976) initially dedicated himself to Husserlian philosophy, though he was never formally a student of Husserl's (Jones, 1975). Hermeneutic phenomenology shares phenomenology's focus on the lived human experience or life world. To provide meaning and a sense of comprehension, the emphasis is on shedding light on the small nuances and seemingly insignificant aspects of our experiences that we often overlook in our daily lives (Wilson & Hutchinson, 1991). Husserl and Heidegger disagreed on the direction this investigation of lived experience should take. Heidegger concentrated on 'Dasein,' which translates to 'the mode of being human' or 'the situated meaning of a human in the world' (Heidegger, 1962).

In contrast, Husserl concentrated on comprehending beings or phenomena. Husserl believed that humans are essentially knowers and are interested in the ways people attend to, perceive, remember, and think about the world. On the other hand, Heidegger believed that humans were essentially concerned beings who focused on their destiny in an unfamiliar world (Annells, 1996; Jones, 1975).

The difference in emphasis between Husserl and Heidegger illustrates a significant change in phenomenology's epistemological position. Heidegger's hermeneutic phenomenology maintains that knowledge is inextricably linked to human experience and interpretation (Heidegger, 1962; Laverty, 2003; Smith et al., 2009). In contrast, Husserl incorporated mathematical concepts, using bracketing and reduction to identify fundamental structures of consciousness (Laverty, 2003). Heidegger maintained that people exist within the world, constantly interpreting their reality through their social, historical, and cultural contexts rather than merely observing it as detached observers. According to this epistemological stance, meaning is co-constructed by lived experience and the interpretation of those experiences rather than being found through objective observation (Laverty, 2003). In this way, the idea of absolute truths is challenged by hermeneutic phenomenology, which posits that knowledge is dynamic and evolves through constant interaction with the outside world. In qualitative research, this knowledge is especially crucial when the researcher uses interpretive analysis to reveal the depth of participants' experiences rather than pursuing a single, unchanging reality.

The "life world" is defined as what we encounter pre-reflectively, without the need for classification or conceptualisation, and frequently consists of things that are taken for granted or constitute common sense (Husserl, 1970). According to van Manen (2016),

phenomenology is the study of lived experience or the real world. Phenomenology focuses on the world as experienced by an individual rather than the world or reality as something distinct from the individual (Valle et al., 1989). This concentration, according to Polkinghorne (1983), is an attempt to fathom or understand the significance of human experience as it is lived. To unearth new and/or forgotten meanings, ordinary and everyday taken-for-granted occurrences of phenomenon become central, are revisited, and re-examined. Although there are many ways to access and understand experiences, people often use language, particularly the narrative structure of storytelling, to make sense of their lives (Smith et al., 2009). People can think about, arrange, and reinterpret their reality by using the storytelling of lived experience to articulate meaning. According to Bruner (1990), one of the primary ways people create and convey meaning, particularly in relation to identity, culture, and subjectivity, is through narrative. The current study uses IPA to investigate how participants recount and interpret these lived experiences. A thorough explanation of how this approach was used in the current investigation will be offered later in the chapter.

3.1.2 Positionality

Research in which the researcher and the participants share the same or similar identity, experiences, or cultural backgrounds is referred to as insider research (Yvonne Bulk & Collins, 2023). This positionality can influence the construction, interpretation, and validation of knowledge during the research process. Insider positionality facilitates in-depth, contextually rich interpretations of lived experiences in phenomenological research, such as IPA (Ugiagbe et al., 2025). Researchers who share cultural backgrounds, linguistic understandings, or lived experiences with participants may be more aware of social conventions, culturally unique phrases, and implicit meanings (Berkovic et al., 2020; Magnusson & Marecek, 2015); they are more likely to identify layers of experience that an outsider may miss. This familiarity necessitates increased reflexivity to prevent the assumption of shared understandings, confirmation of preexisting biases, or the inadvertent projection of personal experiences onto others. According to interpretivism, subjectivity, researcher positionality, and interpersonal interactions all play a fundamental role in the social construction and shaping of knowledge (Pervin & Mokhtar, 2022). Resultingly, the researcher's personal identity, prejudices, and life experiences invariably affect how the

research aims are conceptualised, voices are privileged, and data is interpreted, making continuous critical reflection and methodological openness necessary to support the research process's legitimacy and dependability.

As the researcher of this study, I contribute my lived experience as a first-generation Asian young adult woman with an ADHD diagnosis living in Aotearoa/New Zealand. After learning about other people's experiences through reading and watching stories online, I felt a great deal of concern and anguish for the community of Asian ADHD women. I recognised a crucial disparity: Asian women with ADHD experience increased marginalisation in society and healthcare due to racial and gender bias, yet their experiences are rarely highlighted. This heightened awareness influenced my decision to undertake this research. As a result, I was careful to keep an open mind and refrain from assuming anything about the realities and lived experiences of participants when planning and conducting this study.

Nevertheless, my prior knowledge and life experiences provided a foundation for interpreting the data in this study, and this interpretation served as the basis for presenting the study's findings. This dynamic exemplifies the intersubjectivity principle, according to which participant and researcher jointly generate meaning through discussion and introspection (Smith et al., 2009). A more profound, more relational knowledge of the phenomena being studied is made possible by this study's acceptance of the interpretive space formed by the interaction of our actual experiences rather than its pursuit of detached objectivity.

The disability rights motto, *"Nothing about us, without us,"* advocates for people with disabilities to be involved in research and advocacy. Insider researchers and research designers are needed to ensure that matters affecting the community are prioritised. Having lived experience and being an insider researcher furthers the goals (Francis, 2018). Applying this maxim to neurodivergent research challenges power disparities that have historically oppressed and exploited vulnerable populations and violated the experiences of disabled people (Chapman, 2021; Titchkosky, 2007). Instead, it recognises lived experience as expertise, supporting the epistemological position of hermeneutic phenomenology, and enables more meaningful and pertinent research (Ahlers et al., 2021; Dibley et al., 2020; Oliver, 1992, as cited in Inckle et al., 2023).

Whilst I share essential facets of my identity and lived experience with the research participants as a first-generation young adult Asian woman with ADHD and can approach the research with empathy and insider knowledge, I am conscious of the need to implement

reflexive techniques at every stage of the research process. This will help to ensure my interpretations are based on participants' experiences and supported by thorough analysis. By acknowledging my insider status as a neurodivergent Asian woman in Aotearoa/New Zealand and using participant-led clarifying strategies, such as asking, "Could you please tell me more about that?" to avoid imposing my interpretations in real time, I attempted to minimise researcher bias. By recognising my positionality, I wanted to add a nuanced perspective on the experiences of Asian women navigating ADHD in a Western context whilst also working to strengthen the study's validity.

Between the ages of 14 and 18, I saw seven different mental health specialists. At 14 years old, I was diagnosed with anxiety and depression by a Child and Adolescent Psychologist, where Cognitive Behavioural Therapy (CBT) was unsuccessful in aiding my symptoms. At 16 years old, I was diagnosed with major depression and mild anxiety by a Clinical Psychologist and prescribed a Selective Serotonin Reuptake Inhibitor (SSRI) by a Psychiatric Registrar – the combination of CBT and the SSRI did not successfully aid my symptoms. At age 18, I approached my general practitioner, suspecting I had ADHD. Later, I was diagnosed with ADHD after an assessment with a Clinical Psychologist, a Clinical Social Worker, and a Psychiatric Registrar, and was prescribed a stimulant by a Child and Adolescent Psychiatrist. After being diagnosed with ADHD and receiving the appropriate treatment, my difficulties with anxiety and depression were drastically minimised. Prior to approaching my general practitioner and querying ADHD myself, no previous mental health professional had mentioned or investigated ADHD.

I attended my assessment alone and in secret because my parents were close-minded when it came to mental health. I have attempted to share my diagnosis with my parents. However, they have little to no understanding of neurodivergence, nor are they open to learning due to cultural and generational differences. However, they are aware of my research and show their support as they always have done for academia – a significant topic of focus for Asian parents, superseding concern for mental well-being. My own experience has, therefore, motivated me to do this research. Existing research has shown that females tend to be misdiagnosed or underdiagnosed, and the interpretation of mental disorders in Asian cultures has been generationally stigmatised (Lauber & Rössler, 2007; Nussbaum, 2012; Timimi & Taylor, 2004).

Whilst my past knowledge and life experiences unavoidably influenced my positionality, it is consistent with Gadamer's (1975) idea of the 'fusion of horizons' in phenomenological enquiry. Gadamer (1975) contends that comprehension is an active synthesis of participant viewpoints and the researcher's prior knowledge (horizon) rather than a passive procedure (Laverty, 2003). Hermeneutic phenomenology recognises that interpretation is constantly located and impacted by history, as opposed to aiming for objective detachment. As a neurodivergent Asian woman in Aotearoa/New Zealand, I bring a unique lived experience perspective to the research that intersects with participants' stories. This insider positionality makes a greater contextual appreciation possible. However, it also necessitates reflexivity to keep interpretations rooted in participant meanings rather than preconceived notions. The fusion of horizons is, therefore, about an evolving conversation between the researcher and participants' meaning-making through their narrative storying, where new meanings develop through interpretation rather than forcing one's perspective (Gadamer, 1975).

3.2 Procedure

This section describes the procedures followed to accomplish the study's aim, including ethics, participant recruiting, data collecting, and study execution. Considering the emphasis on navigating stigma and identity among young Asian women with ADHD in Aotearoa/New Zealand, the approach of IPA enabled participants to shed light on the detailed accounts of their lived experiences. Participants who could shed light on the relationship between cultural norms, neurodiversity, and individual identity were explicitly sought. To fully comprehend the more significant study concerns, the data collection approach was designed to allow participants to openly voice their opinions on cultural narratives, family relationships, academic pressures, and their diagnosis of ADHD. Purposive sampling was employed to better match participants with the study's goals and objectives, thereby enhancing the study's rigour and the reliability of its data and findings (Campbell et al., 2020).

3.2.1 Ethics

All research that falls within the scope of the Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants (Massey University, 2017) requires approval from the Massey University Ethics Committee and all psychologically related research carried out in Aotearoa, New Zealand, must adhere to the ethical standards of the National Ethics Advisory Committee (NEAC, 2019). The Code is intended to protect researchers, institutions, and all research participants, as well as specific teaching and evaluation programmes. The values included in Te Tiriti o Waitangi and the Te Ara Tika Māori ethical framework are incorporated into the Code, which expresses the fundamental human rights of respect for persons, autonomy, privacy, and justice (Massey University, 2017). A high-risk ethics application was submitted to the Massey University Ethics Committee for this research, and approval was granted (OM1 25/50). The inclusion of potentially vulnerable participants, such as young adults sharing personal experiences pertaining to mental health, neurodivergence, and cultural identity, made this high-risk classification important (Massey University, 2017). The committee reviewed all procedures and deemed them to meet ethical guidelines for research involving human participants, including recruitment and voluntary participation; informed consent; participant confidentiality; cultural competency; participant rights, including the right to refrain from answering questions and the right to withdraw from the study without penalty up until two weeks after receiving their transcript; justification for amending a transcript; data storage and deletion management, as well as the use of data once analysed; and importantly, safety and support for mitigating potential risks associated with participation in this research.

The methodology, ethics, and overall approach of this research must, therefore, demonstrate cultural integrity by recognising the cultural perspectives, norms, values, and attitudes of Asian peoples. As a first-generation child of Asian immigrant parents in Aotearoa/New Zealand and a neurodivergent Asian woman myself, the results of this research had a lower risk of being misconstrued and overgeneralised. However, with the guidance of my supervisor, I aimed to take extra care to prevent stigmatising and alienating neurodivergent women from other cultural backgrounds. This was achieved by prioritising participant-led interpretation, using inclusive and identity-affirming language, using a reflexive approach, and ensuring that a range of experiences were represented in the analysis.

I also ensured that participant voices were appropriately reflected without perpetuating stereotypes or narratives that focus on deficits and accounted for how neurodivergence is framed differently across different cultures.

3.2.2 Recruitment

Participants were recruited through advertisements (refer to Appendix A) on Facebook groups (Chinese People in New Zealand – 6.9K members; ADHD NZ Community for Adults with ADHD – 17K members; gals in psychology – 48K members; Asians in New Zealand – 39.3K members; Women Navigating Adult ADHD – 1.2K members; Asian Family Services – 1.9K likes and 2.3K followers; The New Zealand Japan Society of Auckland Inc. – 1.9K likes and 2.1K followers), LinkedIn (Asian Family Services – 2K followers; my profile – 200+ connections; Ethnic Research Aotearoa – 2K followers), Xiaohongshu (RedNote), and Reddit (r/NewZealand – 760K+ members). Target individuals also shared the advertisement via social media and with acquaintances who might meet the criteria. Inclusion criteria included being a woman aged 18-25 residing in Aotearoa/New Zealand, having a diagnosis of ADHD and identifying as a first-generation child of Asian immigrant parents (East, Southeast, or South Asia).

Participants contacted the researcher using the email address provided on the advertisement poster (see Appendix A), where they were then asked to confirm that they met the full participant criteria. Eligible participants were provided with an information sheet detailing the research aims, procedures, risks, and benefits (see Appendix B). If the participant was interested in proceeding with participation after reviewing the information sheet, they contacted me by email to convey their intent. They were then provided with a consent form to sign and return electronically (see Appendix C).

3.2.3 Participants

Unlike quantitative research, which asks researchers to quantify data from larger samples, qualitative enquiry demands researchers to concentrate on depth from a smaller group of participants (Liamputtong, 2020). Interpretative Phenomenological Analysis (IPA) places more emphasis on depth than breadth; therefore, a smaller sample size, enabling an in-

depth idiographic analysis, was deemed appropriate and chosen, commensurate with the scope and time limitations of a Master's thesis, being an additional essential consideration (Smith et al., 2009). Depending on the topic's complexity and the requirement for rich, detailed narratives, IPA studies typically involve three to ten participants (Smith et al., 2009). Thus, six participants were considered an appropriate sample size for this study to adequately examine the phenomenon. Only six participants were included in the final analysis, even though seven individuals were initially recruited. Due to discrepancies discovered both during and after the interview, one individual's data was excluded. The individual's eligibility was questioned, and she ceased engagement with the researcher when requested to verify the details required to receive the $50 participation voucher. This incident highlights the importance of maintaining vigilance when recruiting participants, particularly in online or incentive-based settings, to ensure the integrity of qualitative data.

Participants were not required to provide psychiatric reports as evidence of their diagnosis, but they were welcome to do so of their own accord. Each interested participant received an information sheet detailing the research, including the requirements, their rights as participants, and the procedures for storing, sharing, and using their data. The information sheet also contained resources that participants might use as a starting point for seeking support if they became distressed during or after participating in this research. Those who met the criteria and were interested in participation signed a consent form to confirm their interest. Participants were consulted regarding the time and mode of the interview (Zoom or in-person, if local). Following the interviews, each participant was given the opportunity to review their interview transcript to validate accuracy and give ongoing consent for the use of their data.

All six participants were diagnosed with ADHD as adults in Aotearoa/New Zealand. The participants in this study are predominantly of Chinese descent and those from Southeast Asia. All parents of the participants have been residing in Aotearoa/New Zealand for at least twenty years, and only one participant has another family member with a known diagnosis of ADHD. A summary of participant demographics is provided in the table below.

Table 1

Relevant Demographic Information of Research Participants

	Participants					
	A	B	C	D	E	F
Age (at the time of interview)	22	23	19	26	24	20
Ethnicity	Chinese Malaysian	Southeast Asian	Chinese	Chinese	Filipino	Chinese
Parents	Parents immigrated as teenagers (decades unknown). Neither parent has been diagnosed with ADHD.	Parents immigrated in 1990/2000. Neither parent has been diagnosed with ADHD.	Parents immigrated in the early 2000's. Neither parent has been diagnosed with ADHD.	Parents immigrated in the late 1990's. Neither parent has been diagnosed with ADHD.	Parents immigrated in the mid-1990's. Mother passed away when the participant was a teenager. Father has since remarried. Neither parent was/has been diagnosed with ADHD.	Parents immigrated in 1992/1996. Father passed away when the participant was a child. Neither parent was/has been diagnosed with ADHD.
Siblings	One sister with no diagnosis of ADHD.	One sister with no diagnosis of ADHD.	One brother with no diagnosis of ADHD.	One sister with suspected ADHD and one sister with diagnosed ADHD.	Three brothers, all with no diagnosis of ADHD.	None.

3.2.4 Data Collection

This research employed in-depth, semi-structured interviews following hermeneutic phenomenological concepts to facilitate the in-depth verbal sharing of lived experiences (Liamputtong, 2020). In-depth, semi-structured interviews enable a flexible and open investigation of an individual's experiences, allowing participants the freedom to elaborate and discuss what matters to them. It also enabled the researcher to pose questions that helped guide their narrative and reflection, making meaning of their experiences (Liamputtong, 2020). Topics included the tradition of one's family, diagnostic experiences, mental health perspectives, emotional and psychological effects, self and perceived stigma, interpersonal relationships, and academic expectations. Broad, open-ended questions were asked at the start of each interview, for example, "Can you please tell me about your experience living with ADHD?" allowing participants to share their viewpoints and steer the discussion. Prompts were used as necessary to help participants delve deeper into specific descriptions of experiences and situations.

All interviews were conducted in English, as all participants were proficient in the language. Conducting the interviews in English ensured consistency across responses and avoided potential issues related to translation or interpretation. The researcher conducted all interviews via Zoom due to the participants' geographical location. Zoom is an online video conferencing platform that features built-in visual and audio recording capabilities. The interviews lasted between 25 and 90 minutes, with an average duration of 53 minutes. Each interview began with up to 10 minutes of rapport building, followed by a discussion on the purpose of the research. During the rapport-building period, the participants were thanked for taking part in the study. A discussion followed about whether they had participated in research before, what had drawn them to participate in this study, and, when appropriate, they were informed that the researcher also met the participant criteria.

Eight interview questions were asked in the same order for each participant, followed by probing questions to extract data pertinent to the research. After the interview, participants were asked to verify their email addresses so that a $50 digital Prezzy Card voucher could be sent to reimburse them and thank them for their time spent participating in the research. This gesture aligns with ethical research standards, which encompass acknowledging participants' time, emotional labour, and contributions, in addition to obtaining informed consent,

ensuring anonymity, and minimising harm (National Ethics Advisory Committee; NEAC, 2019). Giving a gesture of gratitude affirms the dignity and agency of people who kindly share their lived experiences, is consistent with the concept of reciprocity, and recognises the advantages of involvement (NEAC, 2019).

A Zoom video recording is automatically generated when recording via Zoom. This was deleted immediately, and the audio recording was kept for the production of transcripts. Participants were informed after the interview that they would receive a text copy (or transcript) of the interview and would be asked to validate its accuracy. They were reminded that transcripts could be amended to ensure meaning-making was captured before signing a transcript release form (see Appendix D). In IPA research, amending a transcript is both methodologically and ethically justified, as it helps ensure that participants' narratives and interpretations of their experiences and perceptions are accurately captured. Interpretative Phenomenological Analysis (IPA) prioritises the participant's voice as essential to the interpretative process and is essentially concerned with how people make sense of their lived experiences (Smith et al., 2009). Transcript reviews also respect the participant's agency and uphold the ethical treatment of their stories, which is crucial when working with marginalised groups whose voices are frequently ignored or misrepresented (NEAC, 2019). The interviews were transcribed using Otter AI, an online software. The researcher then reviewed each transcript while listening to the audio recording to ensure that the software had accurately transcribed the entire interview, making any necessary amendments for precision.

3.2.5 Data Analysis

Smith et al.'s (2009) IPA methodology was used to analyse the data. There were multiple steps in the process:

(1) Reading and Re-Reading: To have a comprehensive understanding of the participant's experience, the transcript from each interview was read several times. Each interview transcript was reviewed multiple times to have a thorough grasp of the participant's experience. In keeping with IPA's idiographic commitment, the analysis began with a single case, allowing for a comprehensive and intricate understanding of the lived experience of one participant before proceeding to the next. This method ensured that

every account received careful consideration and depth, allowing themes to emerge naturally from within each unique situation.

(2) Initial Noting: During this phase, thorough notes were taken, emphasising the conceptual, linguistic, and descriptive elements of each participant's story. This procedure made it easier to examine the data closely and allowed for the identification of noteworthy comments and themes in each experience.

(3) Developing Emerging Themes: To make sense of emergent themes that encapsulated key aspects of the participants' experiences, the original notes were examined. Each case was handled differently, paying close attention to maintaining the idiographic richness of each experience and the researcher's interpretive interaction with the information. A cross-case comparison was conducted following this within-case analysis to identify recurring themes and refine the subthemes and superordinate themes. This entailed identifying both points of convergence and divergence, emphasising the commonalities among participants' experiences as well as the unique, personal interpretations that each participant added to their narratives.

(4) Connecting Themes: By identifying common elements of participants' sense-making processes, emerging themes were discerned and grouped into superordinate themes based on trends across individual experiences.

(5) Cross-Case Analysis: Finally, to build a more comprehensive knowledge of the lived experience, themes were analysed across cases to find similarities and contrasts.

A data extraction sheet was developed on a Microsoft Excel spreadsheet, which included key quotes extracted from each participant's interview. This procedure made it possible to guarantee that the interpretation of the results remained firmly based on the experiences and words of the participants (Smith et al., 2009).

3.2.6 Reflexivity

Having considered my personal experiences and positionality, particularly in relation to cultural norms and neurodivergence, I maintained a reflective journal throughout the entire research process. This was particularly helpful during the data analysis phase, where being critically aware of my presumptions, feelings, and biases ensured that the analysis remained grounded in the participants' viewpoints.

Interpretative phenomenology acknowledges that understanding is developed through an iterative process of moving between the parts (individual excerpts or meaning units) and the whole (the overall narrative and context). This is conceptualised as the hermeneutic circle (Smith et al., 2009), consistent with Heideggerian phenomenology (Heidegger, 1962), where researchers invariably add their conceptual frameworks to the interpretive process, requiring reflexivity to manage pre-understandings. I interacted reflexively (through journalling techniques) with these pre-understandings to enhance interpretation rather than trying to bracket or eradicate what I brought to the research project as lived experience and insight. I was able to maintain my openness while attempting to accurately interpret the participants' life experiences using this reflexive approach. Ongoing supervision conversations served as important points of discussion, encouraging a careful examination of the data and ensuring that interpretations were based on the participants' viewpoints rather than being dominated by my own, with participants' quotes being used as evidence of this.

3.3 Research Considerations

The ethical issues relevant to this study's conduct are outlined in this section, including informed consent, safety of participants and anonymity, and cultural considerations. Since the research involved human participants and was focused on the lived experiences of neurodivergent Asian women in Aotearoa/New Zealand, ethical considerations were prioritised to help ensure that participants received respect, autonomy, and dignity throughout the entire research process. Cultural considerations received particular emphasis, acknowledging the impact of stigma, familial expectations, and differing perspectives on ADHD in Asian populations (Corrigan & Kosyluk, 2014; Fabrega, 1991; Jones & Corrigan, 2014; Kaur, 2023; Ng, 1997). The limitations of this study will also be discussed in this section, including methodological limitations and other biases that may have affected the results of this research.

3.3.1 Informed Consent

Prior to the interviews, participants received an information sheet detailing the research, including the requirements of their participation, their rights as participants, and the

procedures for storing and using their data. After reviewing the information sheet, participants were invited to provide their informed consent by signing the consent form, which was sent to them via email. Participants were reminded that they may revoke their consent up until two weeks after receiving their interview transcript, acknowledging that consent is ongoing throughout the interview process. All participants were given the opportunity to review their interview transcripts to validate accuracy and address any privacy concerns, though reviewing was not compulsory. At the end of the interview, participants who chose not to review their transcripts verbally gave their consent, which was recorded on audio. Participants who indicated they would review their transcripts were provided with a transcript release form providing their written consent (see Appendix D).

3.3.2 Safety of Participants, Anonymity, & Emotional Distress

Participants in this study were likely at risk of experiencing distress while recalling unpleasant or traumatic events. The psychosocial and cultural aspects described in the literature review were deeply considered in the formulation of the ethical procedures used in this investigation. For example, there is a significant stigma associated with mental health from an Asian cultural perspective (Kirmayer & Young, 1998; Ng, 1997). Label avoidance, family honour, and shame are some of the variables that contribute to the concealment of psychiatric illnesses (Jones & Corrigan, 2014; Ng, 1997). Given these cultural dynamics, it was crucial to ensure that participants felt psychologically safe and supported throughout the entire study. For example, participants were asked whether their family members, relatives, or broader culture accepted their diagnosis. This was potentially a sensitive topic for those who have either not been received by their family or culture or have no relationship with their family or cultural background. The interviews were conducted with this in mind, and participants were advised that if they felt any emotional distress, they could indicate whether they would like to proceed to the next question, take a break, reschedule the interview, or withdraw from the research.

Neurodivergent differences can also impact psychological safety, especially regarding memories of traumatic lived experiences and support, or lack thereof. This will be discussed further in the limitations section. However, recognition here is offered because it is consistent with the phenomenological focus of honouring the emotional limits and subjective reality of

participants. There were no indications of participant distress, discomfort, or concern throughout the interviews, as no one requested that their interview be stopped or that the process be altered in any way. Additionally, participants did not appear reluctant to share their experiences, including those that reflected considerable trauma. The participant information sheet included a list of accessible and culturally relevant support services that participants might use if necessary. The interviews concluded on a positive note, with participants receiving heartfelt gratitude for their time and input. To facilitate the exit from the interview and ensure that participants felt appreciated and supported, a brief closing conversation was conducted.

Finally, all information was de-identified and safely preserved, demonstrating a moral dedication to protecting identity, which is particularly important in a society where being 'outed' as having a mental health disorder may have long-lasting social and familial repercussions (Liamputtong, 2007). In addition to adhering to ethical research standards, meticulous attention to participant autonomy and confidentiality shows a culturally sensitive approach that acknowledges the vulnerabilities covered in the existing literature on Asian women's experiences with ADHD and mental health. To preserve participant privacy, all identifying information, including names of individuals, clinics, and employers, was removed from transcripts and replaced with pseudonyms. All the data was safely stored in Massey OneDrive, accessible via a password-protected device that only the researcher could access. Separate digital folders were created to store identifying forms such as consent forms and transcript release forms, ensuring these could not be linked to transcripts. This method of storage ensured that data were not linked to specific participants.

3.3.3 Cultural Considerations

Te Tiriti o Waitangi (the Treaty of Waitangi) serves as the foundation for culturally safe research in Aotearoa/New Zealand (Massey University, 2017). The ideals of Te Tiriti o Waitangi – participation, partnership, and protection – were upheld in this study to ensure safe and inclusive research. Despite not being research-specific, Te Tiriti's principles provide general responsibilities for all researchers in Aotearoa/New Zealand. Since cultural understandings inform ethical principles and how they should be interpreted, researchers in Aotearoa/New Zealand must be aware of Māori ethical standards to be good Tiriti partners

(Massey University, 2017). The four guiding principles of the Māori ethics framework put forth in Te Ara Tika – manākitanga (cultural and social responsibility), tika (research design), whakapapa (purpose and relationships), and mana (justice and equity) – were carefully considered throughout this research, and their application was guided through cultural consultation processes. Examples of incorporation are considered below.

A survey report from the Asia New Zealand Foundation (2018) found that Māori perceive themselves as sharing many cultural views and values with various Asian cultures. Māori perceive a great deal of commonality when it comes to the importance of relationships (whanaungatanga), customs surrounding food and hosting guests (manaakitanga), and valuing elders (kaumatua) (Asia New Zealand Foundation, 2018). Regarding Asian cultures outside of my own (Chinese), I did not require assistance from a cultural advisor. However, I made provision for assistance in the case of a participant requesting any specific cultural practices.

While conducting this study, I maintained my flexibility and open-mindedness in negotiating human diversity. For example, when some participants faced difficulties in providing real-life examples relevant to the question, I asked if they would like me to share an example from my own lived experience. In line with kaupapa Māori values such as manaakitanga and whanaungatanga, this culturally sensitive approach ensured that participants felt valued and heard. I was able to create a more welcoming and encouraging interview setting by emphasising relationships and understanding, which potentially improved the calibre and scope of the information gathered. The approach for this research included frequent check-ins and openness regarding objectives and results (partnership), with participants actively shaping how their stories were portrayed (participation). Measures were also taken to safeguard the participants' well-being, such as providing resources for support and guaranteeing confidentiality (protection). According to Māori ethical standards, the Te Ara Tika principles were also incorporated: whakapapa guided meaningful engagement and the recognition of shared identities; tika informed the co-design of interview questions with cultural sensitivity; manākitanga was demonstrated through care in communication and trust-building; and mana was upheld by making sure participants' voices were central and valued in the analysis and presentation of findings.

3.3.4 Limitations

Several limitations were identified within this study, including researcher and participant bias, the depth and detail of participants' answers, recall bias, and temporal factors.

Participant bias, also known as subjective bias, refers to the impact of participants' research awareness on certain study aspects. This is particularly relevant to research approaches that involve various manipulations of variables, especially in experimental settings (APA, 2023). In this research, whilst there were no manipulations or experimental settings per se, participant bias may still have occurred because Asian cultural norms frequently place a strong emphasis on indirect communication, social harmony, and deference to authority (Xiao, 2023; Shen et al., 2024). These elements can affect how individuals talk about delicate subjects, including neurodivergence, mental health, and family expectations. For example, to avoid upsetting cultural narratives of academic achievement or filial piety, people may minimise personal challenges with ADHD.

Furthermore, when participants negotiate both Western individualism and traditional Asian standards, the junction of collectivist beliefs and the diasporic experience in Aotearoa/New Zealand may further influence responses (Ho et al., 2003; Leong & Ward, 2000; Parreñas & Siu, 2007). This study used rapport-building strategies and open-ended, reflective questioning to counteract these cultural biases and promote authentic responses. Anonymity and confidentiality were also emphasised to provide a safer space where participants could feel more comfortable discussing their experiences without fear of criticism. This may have helped participants feel protected, appreciated, and more inclined to talk freely, which was crucial given the intimate and possibly stigmatised nature of the subjects covered.

The thoroughness and specificity may also constrain the study's findings to each participant's responses. Although the purpose of interviews is to elicit detailed responses, individual variances in narrative styles, cognitive processing, and cultural communication norms may lead to disparities in the quality of the data (Au, 2019). Depending on their comfort level with storytelling, memory recall, and subjective interpretation of events, some participants may create in-depth, thoughtful responses, while others may give succinct or disjointed ones. The length of the interview does not always determine the richness of a

participant's story; insightful information can be gleaned from any length of conversation (Seidman, 2013). As a result of this, no conclusions or analyses were made on the importance of a single participant's relatively short 25-minute interview. This participant promptly answered every question without hesitation or pause and seemed uninterested in building rapport despite the researcher's attempts to do so. Although most participants occasionally hesitated to provide more details in their answers, this was not considered troublesome or a sign of concern. ADHD may impact how individuals describe their lived experiences in the context of neurodivergence by influencing verbal expression, working memory, and the ability to organise ideas into cohesive narratives (Low, 2023). While some people may struggle to articulate their feelings, resulting in less thorough reports, others may have hyperverbal tendencies and provide lengthy, tangential comments. This variation in narrative detail necessitated a methodologically deliberate and reflective approach to analysis. Since IPA focuses on the co-construction of meaning between participant and researcher, the objective is to recognise the depth and relevance of each person's account rather than guarantee equal representation in terms of narrative volume or quote frequency (Smith et al., 2009). As a result, decisions had to be made regarding the representation of participant voices, especially in cases where some participants contributed more "quotable" content than others. Keeping in mind the interpretative character of the analysis and the variety of ways participants conveyed meaning, these choices were made to encapsulate lived experiences throughout the dataset.

Due to societal harmony concerns, familial expectations, or stigma, people may be less inclined to openly discuss their challenges, particularly those related to mental health and neurodivergence. Instead, Asian communication norms tend to emphasise high-context, indirect speech (Kang-Yi et al., 2018; Wang et al., 2023). Depending on their exposure to Western individualistic discourses that promote self-expression, some participants may be more willing to share extremely intimate experiences. In contrast, others may be reluctant to do so. Considering this, response depth variability is not only a technical constraint but also a significant component of how individuals create and negotiate their identities within cultural and neurodivergent frameworks (Goodley, 2014). This study considered these variations to promote genuine, participant-led storytelling while honouring unique communication styles and used active listening, flexible questioning, and rapport-building strategies. I approached the interview process with flexibility and reflexivity, acknowledging that these

communication disparities are ingrained in cultural and neurodivergent ways of being. I gave participants autonomy over the breadth and depth of their experiences to reduce the pressure to adhere to Western or neurotypical standards of disclosure. This was accomplished by providing open-ended questions, permitting uninterrupted pauses or silences, allowing participants to skip questions or come back to them later, and reaffirming that there were no 'right' or 'correct' ways to answer.

Additionally, I conducted interviews in locations selected by the participants (all online), avoided strict time constraints, and periodically checked in to make sure they were comfortable during the process. This may have enhanced participants' comfort level with vulnerability, promoted trust, and enriched the data by allowing for a wider variety of meaning-making. The ethical and authentic representation of participants' ways of expressing and making sense of their lived experiences on their terms was the goal of these methodological choices, which went beyond just regulating variability.

Another limitation of this research is recall bias. Recall bias frequently happens when someone recounts an earlier action or incident (APA, 2018). While such retrospective reporting may contain some accurate information, it also often contains inaccurate information, such as systematic under- or overcount of the frequency of a particular behaviour (APA, 2018). According to phenomenology, accuracy is more about the genuineness of experience than it is about factual correctness (Neubauer et al., 2019). Therefore, recall bias is less of a concern in IPA because the goal is to comprehend the subjective meaning that participants ascribe to their experiences rather than measure the frequency of behaviours (Smith et al., 2009). Participants' stories offer important insights into their perceptions, feelings, and identity negotiations – all of which are crucial to this study, even if they forget certain aspects or provide partial or misleading descriptions of past experiences if they cannot recall them accurately. Whilst the researcher could not prevent or minimise the chances of recall bias occurring, they took this factor into account when analysing the data and each participant was provided with a copy of their interview transcript for review. This allowed each participant the opportunity to reflect on their experiences at their own pace, without the pressures and constraints of an interview setting. Only one participant made amendments to her transcript (Participant E) as she was dissatisfied with the depth of her answers during the interview.

Temporal factors can also limit the results of this research (Smith et al., 2009), as participant responses may vary depending on the timing of the interview. For example, the participant may be in a low mood during the interview, have had a poor night's sleep, be facing high levels of stress in their personal or work life, or have other reasons unknown to the researcher. Participants were informed that they could reschedule their interview if they felt they were not in the best state of mind to take part. However, no participant needed to do this.

Despite these limitations and the use of techniques to reduce potential biases and improve the authenticity of the data, the results offer important insights into the intricate interactions of neurodivergence, identity, and cultural environment, even if they may be impacted by factors such as cultural norms, recall bias, emotional discomfort, and temporal impacts. Recognising these limitations highlights the importance of evaluating the findings within their scientific and cultural context.

Chapter 4: Findings & Analysis

The main themes that arose from the Interpretative Phenomenological Analysis (IPA) of the participants' lived experiences as young Asian women who are neurodivergent in Aotearoa/New Zealand are presented in this chapter. The IPA's guiding principles, which place a high value on a thorough, idiographic comprehension of how people interpret their social and personal environments, served as the basis for the investigation. According to this methodology, the results should capture the depth, complexity, and subtlety of participants' meaning-making by highlighting both the similarities and differences among their tales (Smith et al., 2009). As a researcher working in this cultural and neurodivergent context, my interpretive perspective affected the themes that were co-constructed through a reflexive engagement with the data. Verbatim quotes that highlight participants' voices and highlight the importance of their experiences are used to support each theme. In addition to honouring the individuality of each story, this chapter aims to investigate the larger cultural, social, and structural factors that influence how these women navigated identity and stigma.

4.1 Overview

The lived experiences of neurodivergent (ADHD) young Asian women in Aotearoa/New Zealand show a complicated and multidimensional path filled with both personal setbacks and epiphanies. The interviews with six individuals provide insight into the ways that societal beliefs, familial ties, and cultural expectations interact with the experience of ADHD. The findings are presented chronologically, reflecting the temporal and developmental nature of the participants' experiences, specifically pre-diagnosis, during diagnosis, post-diagnosis, and the present. Each phase documents the ongoing processes of coming to terms with oneself as a neurodivergent Asian woman in Aotearoa/New Zealand, as well as the evolving perceptions of ADHD and connection with family and culture. The following analysis reveals five prominent themes with supporting subthemes, as presented in Table 2.

Table 2

Summary of Emergent Themes and Subthemes from Participant Narratives

Period	Themes	Subthemes
Pre-Diagnosis	Pathways to Self-Understanding	Initial Perceptions of ADHD
		Implications of the COVID-19 Pandemic
	Family & Cultural Dynamics	Maternal Dominance & Familial Reactions
		Mental Health Literacy in the Absence of Dialogue
		Epistemic Dissonance
During Diagnosis	Pathways to Self-Understanding	Internal Academic Conformity
	Family & Cultural Dynamics	Cultural & Peer Comparison Dynamics
		Intergenerational Shifts in Understanding
Post-Diagnosis	Post-Diagnosis Identity Reconstruction	Affirmation of Identity
		Internalised Stigma & Reframing Self-Perception
	Negotiating Neurodivergence in Context	Shifting Parental Perceptions
		Navigating Cultural Narratives
Present	Identity, Isolation, & Representation	Expanding the ADHD Narrative
		Belonging & Isolation

4.2 Pre-Diagnosis

Participants navigated a challenging terrain of uncertainty, self-doubt, and misinterpretation prior to being diagnosed with ADHD. Many of them mentioned feeling as though they were 'different' or 'just lazy,' and they frequently internalised these difficulties as personal shortcomings since they lacked the psychoeducation to articulate their experiences. This stage is influenced by familial language handed down and cultural factors that shape how differences are viewed and navigated, as well as personal struggles. The visibility of neurodivergence was sometimes concealed by cultural expectations surrounding achievement, emotional control, and filial piety, which delayed help-seeking and recognition. This section also examines how individuals started their path to self-awareness in settings where ADHD was not discussed or was misinterpreted.

4.2.1 Pathways to Self-Understanding

The prevailing Western societal and media portrayals of ADHD, which defined the disorder as mostly afflicting hyperactive, disruptive Caucasian boys, initially influenced participants' understandings of the disorder. Women, particularly women of colour, are often overlooked due to reductive narratives that excluded more internalised or inattentive presentations, resulting in delays in self-recognition and misattributed problems. The COVID-19 epidemic caused individuals to reevaluate their experiences more critically as everyday routines were interrupted and exacerbated underlying symptoms. Participants' diagnostic journeys underwent a significant shift during this time, as personal reflection and online forums allowed for the exploration of symptoms that had previously been misinterpreted.

Initial Perceptions of ADHD. Participants' initial perceptions of ADHD appeared to be based on the widespread belief that ADHD exclusively afflicted hyperactive males. Prior to receiving a diagnosis, most participants had a narrow understanding of ADHD, relating it mainly to hyperactive young boys rather than a disorder that may impact females and adults or manifest in more subdued ways.

> *The sort of mainstream stereotype of what ADHD looks like, and that's like, you know, a little boy in the class, acting out, being disruptive and noisy. Kind of those hyperactive attributes.* (Participant B)

This quotation serves as an example of how prevailing Western media representations formed participants' limited understanding of ADHD. Other forms of ADHD, especially those more prevalent in females or non-Westerners, were marginalised by the stereotype of the 'disruptive schoolboy.'

> *I knew like one person who had it, and they were a guy who was super outgoing and loud and stuff like that. So, I kind of just didn't really think about it at all.* (Participant C)

Here, extroversion and outward disruption are associated with ADHD, which contracts with the internalised or inattentive experiences that many participants later realised they had. Self-identification and diagnosis were delayed in part because of this discrepancy.

> *I think up until I was diagnosed, I knew of it as the sort of hyperactive boy presentation. There was a kid in my primary school who ticked the bill and had ADHD, and that probably was the last memory I had of what ADHD was.* (Participant D)

This highlights how associations formed in early childhood may persist into adulthood, influencing the symptoms that participants considered to be 'valid.'

Many participants agreed that their actions, which were frequently veiled, silent, or internal, did not fit these stereotypes. This discrepancy caused self-doubt and delayed their recognition of their own ADHD symptoms.

> *I mainly perceived it as the stereotype, where you're bouncing off walls, you're loud and talkative, and you're super quirky and zany. I didn't know there were other ways for ADHD to present than the stereotypical little boy.* (Participant E)
>
> *I think when I was really young, for the longest time, it was only until I was a lot older that I knew what ADHD was. But my view of ADHD was basically just shaped by white boys—just kind of the white boys that can't sit still. You know, they try to be the class clown and the troublemaker. So, very much that kind of mainstream thing, whereas it's so much more than that.* (Participant F)

Incorporating both gender and race, this reflection highlights how mainstream narratives perpetuate a white-centric model of neurodivergence while simultaneously excluding

women, not to mention women of colour and from diverse cultural backgrounds. Participant F and other participants acknowledged how these limited perspectives obscured their own actual experiences as Asian women.

Implications of the COVID-19 Pandemic. As participants did not see their personal experiences represented in popular narratives about ADHD, they experienced delayed self-recognition as a result of this misunderstanding. This also led to the belief that their difficulties stemmed from personal failings rather than a neurodevelopmental disorder.

> *It was bad. It was really bad. I didn't even survive; I didn't pass even Semester 1 in Year 1 of Bachelor's.* (Participant E)

Individuals dealt with external obstacles such as the COVID-19 lockout and unsupportive family relationships while navigating their ADHD diagnosis, from early suspicions to official recognition. Self-reflection and internet research were frequently the first steps they took to identify their symptoms, especially during the COVID-19 lockdown when their difficulties were more noticeable due to greater isolation and changes in routine.

> *I really struggled during COVID. I did my first year of uni before COVID, and then the difference between before and after COVID was so drastic. I really struggled with my mental health that time.* (Participant B)

Here, the story of Participant B demonstrates how the epidemic has had a destabilising effect on executive performance and mental health. Reflection was spurred, and long-standing but previously unnoticed challenges were brought to light by the disparity between pre- and post-lockdown functioning.

> *COVID was really significant for me because that was when I finally pushed myself to seek a diagnosis.* (Participant E)

Academic failure turned into a crucial crisis moment for Participant E. Her decline in academic achievement, which is frequently a protective feature that masks symptoms (Miller et al., 2012; Quinn & Madhoo, 2014) and is also a culturally embedded or internalised measure for one's well-being, pushed her in the direction of a diagnosis. Thus highlighting the role that contextual and systemic changes can play as diagnostic triggers.

> *I think I've always struggled, but then lockdown was just kind of the nail-in-the-coffin type thing.* (Participant F)

Rather than creating entirely new challenges, the COVID-19 epidemic exacerbated preexisting ones, especially for the participants, who would have been in their mid-teens to early twenties at the time – a stage of life already characterised by significant changes in development. Although Participant F had identified a pattern of suffering throughout her life, the pandemic provided the push for her to finally acknowledge and seek support for her experiences.

When considered as a whole, these narratives reveal how the COVID-19 pandemic both exacerbated individuals' symptoms and prompted critical introspection. Many turned to internet forums, research, and self-reflection to make sense of their experiences, often for the first time in a meaningful way, after established resources were removed and their everyday functioning was disrupted. The path to self-awareness, diagnosis, and ultimate acceptance of neurodivergent identity became a turning point during this time for many.

Ultimately, the participants' paths to self-awareness were characterised by protracted periods of internalised uncertainty and misrecognition, which were influenced by gendered stereotypes, cultural standards, and a lack of representation in the mainstream narratives surrounding ADHD. Since ADHD was once thought to affect hyperactive, disruptive white boys, many people disregarded their own difficulties, which frequently showed themselves silently and internally. Instead of neurodivergent differences, a sense of personal inadequacy was exacerbated by exposure to their Asian cultural community (family who had perpetuated and reproduced stigma narratives around mental health from their conception) and lack of exposure to broader representations of ADHD within the broader media. On the other hand, Western social media opportunities and access to online neurodivergent communities have become effective means of self-identification, providing people, including these participants who are embedded in NZ Western sociocultural contexts with relatable, alternative narratives that validate their own experiences. By disrupting habits and intensifying symptoms, the COVID-19 pandemic further accelerated a personal search for understanding, creating the urgency and space for introspection. Together, these intersecting elements demonstrate how individuals navigated intricate sociocultural environments to make sense of their experiences, laying the groundwork for what would become an official diagnoses and the reconstruction of identity.

4.2.2 Family & Cultural Dynamics

This theme examines how a protracted period of self-doubt and misrecognition in the participants' lives was caused by a lack of familial communication, competing epistemologies, and insufficient mental health literacy. Participants described the intricate interactions between cultural stigma, emotional silences, and familial expectations that influenced their early perceptions of themselves and their challenges prior to receiving an official diagnosis. Mental health was either not discussed in their homes or was presented in a moralistic manner through stories of perseverance and discipline. Emotional isolation, delayed identification of ADHD symptoms, and internalised stigma were frequently the results of these dynamics. A larger cultural unwillingness to interact with neurodivergence was shown by the frequent invalidation of participants' early attempts to express their difficulties, especially from maternal figures.

Maternal Dominance in Narratives of Familial Reactions. Participants often faced doubt and invalidation from family members, especially maternal figures, despite the personal significance of mental health. Mothers were frequently characterised as contemptuous or unable to accept the validity of a potential ADHD diagnosis, which reflected more significant cultural stigmas and a lack of knowledge about mental health in many Asian communities. Given the personal relevance of the realisations participants were starting to form, these responses were perceived as distressing and perplexing. According to the IPA framework, these situations are not only interpersonal disputes. However, they are also important locations for meaning-making when people analyse their developing neurodivergent identities in light of societal standards, expectations from their families, and their own self-perception (Smith et al., 2009).

> *She [her mother] was just like, "You're fine. Everything's fine. You just need to try harder," or whatever. It kind of went against everything she believed, but I don't really talk to her much, so it's fine.* (Participant C)

A recurrent theme in this instance is familial invalidation that is framed through moral strength and effort, as demonstrated by Participant C. The notion that neurodivergent individuals are 'lazy' or 'unmotivated' is reminiscent of collectivist cultural ideals that emphasise self-control and tenacity (Mavia-Zając, 2024). Silence or emotional distance, as in

"I don't really talk to her much," has evolved into a coping strategy for dealing with these unresolved conflicts. Additionally, Participant C interprets her mother's response as a symbolic challenge to the validity of her self-perception. A deeper cultural script that links adversity with insufficient effort is seen in the casual dismissal of her troubles ("*just try harder*"). Such interpretations have the potential to make individuals feel guilty or inadequate by making them see their difficulties as moral or personal failings. The tension between self-discovery within the Western context of a growing understanding around ADHD and the OK-ness to discuss mental health resulted in a wedge coming between the maternal relationship. These first generation children were being exposed to Western thinking around reasonable disclosure and potential diagnostic understandings underpinning genuine challenges whilst their parents, especially mothers, were holding fast to cultural norms aimed at reproducing and passing on ingrained narratives that mental illness could be overcome by management of laziness.

> *My mum, she was a staunch believer in the idea that I'm not mentally ill. Even though we'd argue, and I'd lash out at her during those arguments, she didn't seem to believe anything was wrong.* (Participant E)

Participant E highlights a protracted conflict between parental denial and emotional expression. The cultural weight of psychiatric stigma and the challenge of being viewed within that context is conveyed by the inability to accept 'mental illness,' which goes beyond simple disagreement. The participant's frequent emotional outbursts emphasise the psychological costs of being made invisible in one's distress and indicate a battle to be acknowledged and validated.

> *But my mum's like very, I guess, traditional in the way, like, "Oh, you have like an illness," or something like that. "We'll just kind of like pray it away" type of thing. Like, "Oh, we'll just like put it under wraps. Like, oh, you don't actually have this."* (Participant F)

A cultural logic of hiding, where difference is viewed as a danger to public image or family unity, is embodied in the framing of ADHD as something to *"pray away"* or *"put it under wraps"*. Many participants expressed an internalised struggle between their lived reality and their families' preferred narratives, which is further exacerbated by this.

> *When I did try to tell my mum because the Western thing to do is you tell your parents, and then they kind of support you. But then, obviously, my mum was like,*

> *"What? What the hell?" And then like arguments and stuff like that. But then I think she could really see that I was struggling as well.* (Participant F)

There is a sense of cultural discord in Participant F's reflection, especially when she compares her experience to what she believes to be a 'Western' standard of parental support and instead encounters misunderstanding and opposition. However, a tiny change – the acknowledgement of apparent suffering – occurs during this confrontational moment. This implies that embodied discomfort overtook words as the most convincing mode of communication for some people. It is difficult to overestimate the emotional impact of these exchanges.

In addition to delaying diagnosis, the lack of support caused many participants to lose faith in relational spaces that were supposed to provide safety and care. Their sense of coherence and self-confidence were also disrupted, in addition to the interpersonal rift.

> *I was like, "Maybe I can just manage myself knowing this to myself." But then it would always bother me.* (Participant A)

The intense ambivalence that many participants experienced is captured in Participant A's quote. Although it is a protective tactic that protects her from criticism from others, the idea of quietly controlling her problems ultimately falls short. Her remarks highlight the persistent need for outside approval, not just for validation but also as a means of stabilising and confirming one's developing identity.

Overall, familial resistance to participants' attempts to make sense of their experiences, especially from maternal figures, reflected ingrained cultural stigma and a lack of knowledge of ADHD and openness to learning about it. In addition to impeding early recognition, this lack of affirmation fuelled internal conflict and self-doubt. These difficulties were exacerbated by a lack of candid discussion about mental health in the family, which influenced how participants managed their emotional well-being and sought help, as discussed in the section that follows.

Mental Health Literacy in the Absence of Dialogue. The absence of discussion at home caused participants to grow up knowing very little or nothing about mental health. Many, therefore, resorted to self-education through online resources, underscoring the lack of psychoeducation in families as well as the significance of digital spaces in forming their knowledge.

The concept of it [mental health] certainly didn't exist at home. (Participant A)

The majority of participants reported that their families hardly ever, if ever, talked about mental health at home. Participants described mental health as a taboo subject, while others said their parents did not see mental health issues as a genuine concern but rather as a show of weakness.

So, from, probably from childhood up to about starting university, I had probably little to no concept of mental health. (Participant D)

Participants were raised with a limited or fragmented understanding of mental health due to the lack of mental health discourse in their homes. Many of the participants only came into contact with the concept of mental health through formal education or peer interactions because they lacked familial language or conceptual frameworks for emotional well-being.

I wasn't really conscious of mental health being a part of your health until, I guess, learning about it in school. (Participant B)

Participant B illustrates how mental health was initially viewed as distinct from overall welfare, and it was only after it was defined within institutional contexts that it began to be recognised. A lack of personal resonance of previous exposure at home is indicated by the conditional tone (*"I guess"*), which emphasises the ambiguity and disengagement that accompanied this learning.

In a similar vein, Participant C talks of a passive awareness that is influenced by school programming and peer norms but lacks internalisation or urgency.

It was kind of just anxious teenagers. I don't really think too much about it. I knew, at least at school and stuff, it was something that was seen as really important, but I just didn't really care too much about it. It was kind of that thing that they just had to do. (Participant C)

Instead of being something pertinent to one's own life, mental health was viewed as a performative duty ("*that thing that they just had to do.*") This suggests that school-based mental health education might be viewed as impersonal or inauthentic if there are no underlying conversations taking place at home, especially if it is not culturally anchored. For many participants, the process of self-education regarding neurodivergence, in particular, ADHD, turned out to be both crucial and conflicting. Since mental health was rarely discussed in their households, participants found it challenging to bring up their struggles, fearing dismissal or misunderstanding.

> *I didn't feel comfortable sharing with, say, my mum, if I was feeling really sad or whatever, or feeling really stressed about school or whatever, I felt like I couldn't tell her because that's not something we do.* (Participant B)

The statement made by Participant B shows how family standards that subtly restricted emotional expressiveness were internalised. Vulnerability is not viewed as appropriate or acceptable in family interactions, as encapsulated in the phrase "*that's not something we do*."

> *I was exposed to very negative expressions of emotions that probably caused me to go to think very differently about the way I should express my own feelings and how to deal with them.* (Participant D)

Similarly, Participant D references early examples of maladaptive emotional regulation, which influenced a skewed perception of how to express or manage discomfort. Later attempts to express or comprehend emotional experiences associated with neurodivergence were hampered by this early programming.

> *My brothers accept that I have a mental illness, but they don't get it either.* (Participant E)

Participant E highlights the discrepancy between superficial acceptance and more profound comprehension. Family members may accept or tolerate a diagnosis, but this does not always translate to genuine understanding, empathy, or support, which can exacerbate feelings of estrangement. Early and ongoing experiences of feeling misunderstood can have a particularly significant influence on the self-concept and coping mechanisms of people with ADHD who are prone to rejection sensitivity dysphoria (Dodson, 2025). In contrast, people with ADHD tend to thrive when they are recognised and validated, resulting in something akin to a sense of euphoria (Hallowell & Ratey, 2025) The difficulties participants encountered navigating their neurodivergence within family systems that lacked emotional literacy and culturally appropriate mental health frameworks, therefore indicate significant adverse developmental conditions for young Asian women. Self-education therefore developed into a coping mechanism for survival, but it also highlighted the emotional strain of overcoming a lingering divide between individual wisdom and family rejection.

In an attempt to learn more, one participant researched websites of mental health organisations, including Youthline, The Lowdown, and Depression.org.nz. Despite being significant sources of information widely disseminated throughout Aotearoa/New Zealand, they often fail to represent the country's heterogeneous population accurately.

> *While you wait to sit in the counsellor's office, there's all those like self-help pamphlets, so I started to do my own research. I went to every single website there was - Youthline, The Lowdown, Depression.co.nz or whatever, and then I would read more. It felt like it [mental health] only existed for white people.* (Participant A)

For instance, they mainly discuss mental health from a Western perspective, offering little to no information that is culturally appropriate for Asian populations. Resultingly, young Asian women may feel invisible or misinterpreted in these settings. According to research, Asian populations in Aotearoa/New Zealand face substantial obstacles when it comes to seeking treatment, including cultural stigma, language hurdles, and unfamiliar healthcare structures (Chow & Mulder, 2017). These elements have a part in these communities' underutilisation of mental health care. Thus, resources that are inclusive and culturally safe are essential for providing fair mental health care.

Epistemic Dissonance. Participants were able to authenticate their lived experiences and gain a better understanding of their cognitive profiles by engaging with research, support groups, and personal narratives. However, this increased consciousness also highlighted the contradiction between their developing self-awareness and the constrained or inaccurate viewpoints that their family and cultural communities maintained. Since those closest to them did not always acknowledge or appreciate their observations, participants grew prone to experiencing feelings of isolation as a result. The emotional strain of needing to balance individual knowledge with social misunderstanding was highlighted by this epistemic gap, which also strengthened a sense of estrangement.

> *They [her parents] sent me to the counsellor to talk about my feelings, but I've never done that before. Especially not at home. And so, my view on mental health at the time was like, well, you don't even know it was a thing.* (Participant A)

Participant A serves as an example of how institutional and home knowledge diverge. Being referred to a counsellor was perceived as a confusing break from a custom in which feelings were rarely expressed rather than as an extension of preexisting family support: *"I've never done that before."* Not at home, in particular. This quotation emphasises the lack of emotional support at home, where mental health was almost non-existent in conversation, in addition to the novelty of official mental health participation.

Participant B uses the expression *"we just suck it up"* to further explain this emotional inarticulacy.

> *We [her family] don't feel stressed and complain about it; we just go through it, we just suck it up, and everything will get better or whatever…little things that they say, they all kind of add up to this picture that it doesn't seem like they're as open to the idea of mental health and struggling with mental health and that that's like a normal part of being human and that it's okay and stuff.* (Participant B)

This reflects a stoic culture in which showing signs of distress is perceived as a sign of weakness or failure. A pattern of micro-invalidations that discourage vulnerability and establish silence as the standard reaction to psychological stress is shown by the accumulation of what B refers to as *"little things that they say."* These discursive settings have the potential to erode the validity of an individual's emotional reality and genuine struggles with ADHD challenges, thus promoting internalised stigma and preventing self-disclosure.

According to Participant D, there is a lack of *"mental and emotional literacy"* in her family, which emphasises both a knowledge gap and a reluctance to pursue it.

> *If you don't feel well, more in a mental and emotional way, mum and dad didn't have that kind of literacy to go, "Oh, we can go visit services, so counselling, therapy." They're also extremely private people. So, I think there's that thread of going, "We don't share that kind of stuff with strangers.* (Participant D)

Her statement that *"we don't share that kind of stuff with strangers*" refers to an imported societal value circulating within Asian cultures and family lives of first-generational families. Emphasis is placed on privacy and self-control that stigmatises asking for help. The idea that therapy is a breach of family norms rather than a resource serves further to solidify the gap between individual needs and familial expectations.

Participant E describes her initial attempts to express psychological suffering, which were received with moralising and denial:

> *When I was younger, I would try to tell my parents about the suspicions I had towards my mental health, with my later-diagnosed depression, and they would tell me, "Oh, you're not depressed, you just need to discipline yourself", even when I'd cry or yell at them that something was wrong.* (Participant E)

Mental health problems are frequently pathologised through a moral perspectives across various cultural contexts. This is like redefining neurodivergent or emotional challenges as character faults rather than valid disorders. The severity of Participant E's response *"even when I'd cry or yell at them,"* highlights the need to be understood, the cultural tensions, and possibly, the agony of being rejected and the need for acceptance.

For many, navigating mental health as a neurodivergent individual meant existing in two contrasting worlds, one where they had access to knowledge and self-awareness and another where those around them remained unaware or resistant to these conversations. When taken as a whole, these stories highlight the psychological costs of navigating two distinct epistemological frameworks: one grounded in empirical knowledge and experience and the other in cultural shame, disinformation, and familial silence. Between the two are the elevated emotional intensities that are frequently linked to ADHD, such as acute sensitivity, pain, and frustration, which make it more challenging to make sense of one's identity and lived experience (Skirrow et al., 2014). Participants must constantly negotiate to belong within systems that misinterpret or delete their reality due to the psychologically exhausting dualism created by the conflict between internal lucidity and external invalidation.

4.3 During Diagnosis

A significant turning point in the participants' quest for self-understanding was the diagnostic process. Many found that receiving an official diagnosis of ADHD provided a long-awaited reason for their challenges throughout their lives and helped them view past situations in a more sympathetic light. This period was marked by emotional complexity, as relief was frequently accompanied by loss, uncertainty, or anxiety about how the diagnosis would be viewed by family and in cultural contexts. Participants were navigating the significance of the 'label' in connection to their internalised narratives, cultural identities, and familial expectations as they started to express their neurodivergence and tell of their diagnosis. This section discusses the complex relationship between cultural belonging and personal development by examining how the diagnostic process sparked both relational tension and personal insight.

4.3.1 Pathways to Self-Understanding

This section explores how participants dealt with the challenges of creating an ADHD identity during their diagnostic processes while juggling the demands of academic success. Participants struggled with both implicit and explicit demands for conformity as a result of the interaction between external sociocultural norms and interior neurodivergent experiences. The executive functioning issues that are typical of ADHD often conflict with academic achievement, which is commonly portrayed in many Asian cultural contexts as a crucial indicator of success and filial obligation (Carrasco et al., 2022; Thorell et al., 2012).

Internalised Academic Conformity. This subtheme examines how, frequently in contrast to their difficulties with ADHD, participants internalised academic achievement as a key component of their sense of self-worth and familial validation. The participants talked about a generalised feeling of conflict between their neurodivergent profiles, especially issues with executive functioning, and the high academic requirements that their families either directly or implicitly impose. Participants internalised a strict academic ideal as a result of these expectations, which were not always explicitly enforced but were frequently acquired through cultural norms, familial attitudes, and societal comparisons.

> *So, the Dean really wanted to talk to one of my parents. So, I came to my mum, and I was like, "Hey, I'm really struggling, so the Dean wants to talk to you." She was so mad. She was like, "Why do you do this?" I can't remember exactly what she said, but she was like, "Why do I have to talk to the Dean? Like, why are you doing bad at school?"* (Participant A)

Participant A illustrates the guilt and shame that can accompany poor academic performance, particularly when a parent becomes involved in school-related issues. Her mother's response, which was one of annoyance and/or anger rather than worry, implies that academic difficulties were seen as personal shortcomings rather than signs of need. This reflects a larger cultural discourse that limits the space for acknowledging vulnerability or neurodivergent needs, prioritising academic achievement over emotional or cognitive challenges.

> *They're [her parents] not very strict on schooling and stuff…I guess they think going to uni and stuff is important… not super traditional, but not progressive either.* (Participant C)

Participant C draws attention to her parents' more equivocal attitude, which is neither purely conventional nor progressive but is nonetheless rooted in a culture that views higher education as a necessary prerequisite. This suggests that when academic success is taken for granted, even more lenient family attitudes can nevertheless subtly influence behaviour.

In retrospect, with maturation, Participant E realises how the surrounding cultural milieu influenced internalised pressure and was self-imposed rather than necessarily coming from outside sources.

> *With the perspective I have now, they [her parents] didn't have that expectation of straight A's, 100%, like I'd convinced myself.* (Participant E)

This implies that societal norms can become so deeply ingrained that people may adopt them without explicit enforcement, which may result in self-criticism and increased anxiety when those norms are not met.

> *I think there's still a lot of that traditional belief like, "Oh, you have to study well," I remember as a kid, when I complained that I don't have any friends. They [her parents] would just be like, "Well, what do you need friends for? That's not going to get you into university."… "I think especially East Asian, but specifically like Chinese culture, maybe like growing up, there's that like, "Oh, you just focus on your studies, like don't do anything else."* (Participant F)

This quote from Participant F highlights the East Asian cultural value of prioritising academic success over emotional or social needs, such as friendships, in academic settings. In addition to delegitimising her emotional needs, her parents' rejection of her social struggles (*"What do you need friends for?"*) also serves to uphold the dichotomy between emotionality and productivity. This is an example of a culturally ingrained stoicism that values academic usefulness over overall well-being (Fang et al., 2022; Schunk et al., 2021).

Collectively, these statements demonstrate how academic conformity was frequently internalised as a means for family members to feel a sense of belonging and value. This created a notable strain for participants because the cognitive symptoms that hindered their academic competence were the same ones that discredited their position in this performance-based value system. This led to increased identity conflict, self-doubt, and feelings of failure.

Participants were in a constant state of negotiation as they tried to balance their own constraints with deeply rooted cultural expectations of achievement due to the conflict between academic standards and lived neurodivergent realities.

4.3.2 Family & Cultural Dynamics

This section examines how participants navigated their ADHD identities within a complex web of peer comparisons, cultural expectations, and shifting generational values. Comparisons with both Asian and non-Asian classmates exacerbated the deeply ingrained cultural expectations that many people had about academic success and self-discipline. These dynamics of comparison frequently exacerbated internalised stigma and led to feelings of inadequacy. Despite these constraints, participants also reported slow intergenerational changes in family attitudes, particularly regarding mental health and neurodiversity, which promoted greater empathy and more candid communication. Nevertheless, negotiating social and familial expectations continued to be a complicated and emotionally draining process that required constant balancing of self-concealment, belonging, and authenticity. Collectively, these subthemes highlight the complexity and dynamics of identity formation for neurodivergent Asian women in a Western context.

Cultural & Peer Comparison Dynamics. Comparisons with both Asian and non-Asian peers, both direct and indirect, often influenced and heightened the participants' internalised cultural expectations. Academic achievement, behavioural discipline, and emotional control are viewed as important markers of success and family respect in many Asian cultural systems (Sue & Okazaki, 1990). These norms are particularly out of alignment for neurodivergent people, notably those with ADHD, whose cognitive profiles frequently involve difficulties with executive functioning. A chronic sense of failure was cultivated by this misalignment and exacerbated by ongoing exposure to peers who appeared to embody these cultural values.

Several participants considered how these relationships influenced their internalised feelings of guilt and insecurity. For instance, Participant A said, *"I think my parents were good; they always told me not to compare myself to my sister,"* indicating that although direct comparison was discouraged, there was still an underlying expectation to measure up.

This implies that comparison remained a background pressure, supported by cultural narratives surrounding sibling achievement, even in familial settings that were supposed to be supportive. Some, such as Participant B, emphasised the differences between their upbringing and that of their peers who are not Asian. She highlighted the apparent emotional and relational divide between her family experience and that of her European acquaintance by remarking that there are *"a lot of big differences between how her mum was with her, like how she was raised and how my parents were like at the time."* These parallels extended beyond scholastic standards to encompass broader parenting approaches, particularly in regard to autonomy and emotional support.

Participant E offers a more nuanced assessment:

> *If I compared it to the Asian friends I've had throughout the years, they're surprisingly lax in comparison.* (Participant E).

The diversity of cultural expression is demonstrated here by the fact that not all Asian families strictly adhere to stereotypical standards of behaviour. Even when experiences contradict societal narratives, the act of comparison itself discloses the participant's internal standard for what 'should' be expected.

The conflict between specific familial experiences and more general cultural standards is reflected in the way Participant F presents affirming experience as an exception to the rule.

> *I've heard experiences from my peers growing up, like my other Chinese friends or classmates. For example, when they were growing up, their parents wouldn't support them, for instance, if they played hockey. I played hockey, but my mum was actually decently supportive.* (Participant F)

The idea of an underlying cultural script that participants continuously negotiate against is reinforced by the recognition of supportive parental action while maintaining its status as somewhat atypical.

Overall, these comparative experiences illustrate how cultural standards are continually reevaluated through social interaction, in addition to being passed down within families. Participants were susceptible to emotions of loneliness and inadequacy because of the conflict between their lived neurodivergent experiences and culturally accepted values. In addition to being just observational, these comparisons, both ethnic and non-ethnic, actively influenced the participants' sense of legitimacy, identity, and belonging. They draw attention

to the difficulty of juggling two different consciousnesses: one based on personal hardship and neurodivergent understanding and another influenced by the norms of success and value in their cultural communities.

Intergenerational Shifts in Understanding. Some participants recognised a slow change in their families' attitudes towards mental health and neurodivergence despite the fact that cultural norms surrounding behavioural conformity, emotional regulation, and academic achievement remained firmly established. These minor adjustments, which frequently surfaced over time and through repeated discussions, pointed to a gradual but significant generational shift. Even though ADHD was initially misinterpreted, disregarded, or even pathologised in the cultural contexts of the participants, continued discussion and changes in relationships made it possible for greater empathy, openness, and re-examination of preconceived notions.

> *But then I think just a lot more conversations were happening, you know? And my parents started to be way more understanding, and so they got a lot more open-minded.* (Participant A)

Participant A's comment encapsulates the idea that change was fostered through ongoing, sometimes awkward, interpersonal negotiation rather than emerging on its own. The pluralisation of "*conversations*" suggests ongoing participation as opposed to a single epiphany, indicating a process-oriented change in family perspectives.

> *I think with my dad, definitely. But I think with my mum, she seems more flexible. Especially as I've gotten older, I think she's been more open-minded.* (Participant F)

Similarly, Participant F said, *"I think my mum [her mother] has been more open-minded, especially as I've gotten older,"* implying that life stage and maturity also contributed to the reconfiguration of parent-child dynamics and perhaps respect for their academic ability to make sense of the literature in light of their internal experiences. While greater autonomy and communication encouraged parental flexibility and respect for lived experiences, age seemed to promote reciprocal understanding.

However, these changes were not always total or obvious. Participants questioned if their families really understood the ramifications of neurodivergence because, in many instances, acceptance seemed flimsy or emotionally unanchored. Participant E remarked, *"But I have no idea if he [her father] understood the weight of that, that his daughter's brain*

functions differently than most", thereby expressing a type of epistemic dissonance that persists even in the face of seeming acceptance. When generational understanding is not coupled with more in-depth contemplation or empathy, an emotional divide may persist, as this remark illustrates. It emphasises that although perceptions may change over time, a proper understanding of what neurodivergence entails, especially for a loved one, is not always assured or felt. Despite improvements in relationships, this resulted in a persistent feeling of emotional detachment for many.

The findings illustrate how intergenerational relationships evolved, with parents increasingly shifting from strict frameworks of compliance and achievement to more flexible, emotionally sensitive forms of support. Participants acknowledged that this change was not equally distributed or experienced by families, communities, or cultural enclaves in any case. Instead, it represented a more general, albeit unequal, change in society where the stigma associated with neurodivergence and mental health, but still evident, was starting to wane. Participants discussed the continuous process of navigating their identities in light of deeply ingrained social and familial expectations, notwithstanding these successes. Self-acceptance was rarely attained in a straight line and was frequently characterised by a careful balancing act between expectations from the outside world and one's own needs. Many participants still felt the need to conceal their ADHD symptoms or only reveal their diagnosis in certain situations, especially in settings where conventional standards still held sway. The need to maintain harmony, refrain from passing judgment, and have a sense of belonging within one's family and cultural community was linked to this guardedness. According to the participants, this identity work is dynamic and emotionally draining, needing ongoing rebalancing between acceptance and authenticity.

The 'conflict between conformity and authenticity' captures a fundamental paradox: People frequently run the risk of becoming estranged from the very structures, families, cultures, and communities that formed their social underpinnings in an effort to acknowledge their neurodivergent identities. On the other hand, if they were too tightly aligned with those institutions, they ran the risk of repressing important facets of their identities. Finally, this subtheme emphasises how cultural adaptation in the setting of neurodivergence is changing, but not without conflict. It draws attention to the potential for intergenerational empathy, as well as the ongoing effort that neurodivergent people must put into balancing conflicting

cultural, familial, and personal narratives as lone researchers, advocates, and educators in their families.

4.4 Post-Diagnosis

Participants talked of a profound period of introspection and identity reconstruction after receiving an ADHD diagnosis. For most participants, the diagnosis served as a turning point, helping them reframe their previous difficulties and rethink their self-perception. The diagnosis provided an interpretive framework that allowed individuals to reinterpret lifelong experiences of dissonance, perceived failure, and internalised shame rather than just acting as a clinical label. Participants experienced both relief and turmoil during this post-diagnostic phase as they struggled with what it meant to be neurodivergent in their social, familial, and cultural contexts. This section's themes and subthemes examine how these neurodivergent Asian women in Aotearoa/New Zealand dealt with the existential, relational, and emotional complexities of having a recently identified ADHD identity.

4.4.1 Negotiating Neurodivergence in Familial & Cultural Contexts

For the participants, navigating disclosure within family networks proved to be a challenging and emotionally complex procedure. Many described how difficult it was to explain their ADHD diagnosis to parents who were frequently ignorant, misinformed, or swayed by cultural narratives that portrayed neurodivergence as either Western pathology or weakness. This section examines the two conflicts that participants faced: the evolving and occasionally conflicting parental reactions over time and the larger cultural discourses that influenced how ADHD was perceived, accepted, or disregarded. When taken as a whole, these themes highlight the emotional toll that seeking acceptance and legitimacy within families takes, as well as the constant negotiating that is necessary to overcome the epistemic gaps between clinical and cultural conceptions of mental health.

Shifting Parental Perceptions. When it came to telling family members they had ADHD, not all participants were in the same place, and some struggled with the emotional burden of potential repercussions. Disclosure was a complex process that involved constant

contemplation of timing, expected responses, and the emotional toll of teaching others. This internal tension was articulated by one participant, who said:

> *I just kind of didn't want to go through the logistics of having to maybe like educate her [her mother]and just finding the same page and having just that conflict when I can just like not...* (Participant F)

Participant F was not necessarily afraid of being rejected outright or facing harsh penalties. What shows up instead is a more subdued, but no less potent, unwillingness to engage in emotionally taxing exchanges that could cause discomfort or strain in relationships. The hesitancy stems from the silent calculations of emotional cost rather than a lack of bravery. She continues by elaborating:

> *She [her mother] wouldn't kick me out the house or disown me, but I don't want to have that uncomfortable conversation thing, for me at least. (Participant F)*

This draws attention to a crucial detail: emotional distress and the weariness of bridging cognitive and cultural divides are more often the causes of fear of damage than physical or social exclusion. It depicts an ongoing process in which the person balances the emotional risk against the possible connection. This participant's hesitancy highlights how disclosure occurs on a changing timeline – dependent not only on the other person's readiness but also on the neurodivergent person's ability to handle the fallout from that disclosure, in contrast to narratives of open communication or instant acceptance. The ambiguity of potentially having to educate her mother reveals the slow, intricate choreography required in negotiating identity within familial institutions by implying a liminal place where action is contemplated but not yet taken.

The majority of participants reported that their parents were either uninformed of ADHD or had misconceptions about the disorder before they were diagnosed. Not all participants disclosed whether a parent had accompanied them to their assessments. Interview questions regarding the diagnostic process were kept to a minimum as the aim of the study was not to ask specifically about the diagnostic process, but to focus on identity and stigma. Early responses that defined ADHD as a personal weakness or a Western construct were frequently demeaning and influenced by deeply ingrained cultural norms. Five out of six participants decided to tell their parents about their condition despite these emotions, indicating both the emotional burden associated with the act of disclosure and a need for recognition. According to the participants' testimonies, their families frequently lacked

psychoeducation about neurodevelopmental disorders, which impeded early support and comprehension. Nonetheless, individuals reported minor but significant changes in their parents' perspectives over time in several storylines. These alterations often appeared gradually and were triggered by repeated attempts to explain the situation, emotional intimacy, or the observation of the child's everyday difficulties with executive function.

Though not often stated directly, indications of shifting opinions were apparent in the form of subtly expressed worry, updated expectations, or a readiness to hear experts. These findings imply that emotional commitment, exposure, and ongoing communication might all be effective strategies for promoting acceptance.

> *I think the easier way to describe it is they [her parents] may not deliberately go out of their way to, like, say, look up neurodivergence and what that means, but they're receptive. So, they are supportive. If I send things and resources to my mum, my mum will definitely go and have a look. I think Dad doesn't seem to be quite so interested.* (Participant D)

Participant D's statement exemplifies the complex and perhaps erratic character of family interactions with neurodiversity. One parent may be open to learning and changing, while the other may not care or be involved. These differences highlight how difficult it may be to navigate neurodivergent identification in collectivist family structures, where attitudes towards talking about mental health might vary not only between cultural groups but even within the same household. These results cast doubt on the propensity to generalise cultural norms and emphasise the significance of investigating how resistance and support might coexist in dynamic, changing ways.

Navigating Cultural Narratives. While shifting perceptions offered some participants a sense of relational progress, many still encountered a broader cultural friction in how ADHD was framed and understood within their families. A striking theme in several accounts was the characterisation of ADHD as a 'Western concept', a framing that delegitimised it by associating it with foreign or indulgent ideas rather than neurological facts. This perception reflected a deeper epistemological divide, or clash between Western psychiatric models and culturally embedded narratives of behaviour, responsibility, and mental health.

> *I think coming back to that question about, "Are your parents traditional?" I think some people in my family seem to have a very strong opinion about mental health. It's that like, "gotta tough it out and not show your vulnerability.". And I wouldn't even know where to begin to explain what ADHD is, which I think is a bit ironic because it's genetic.* (Participant B)

Participant B realises ADHD is regarded as neurological and heritable in Western terminology, yet it is still linguistically and conceptually ambiguous in her cultural setting. Since emotional control, fortitude, and stoicism are highly valued in many collectivist Asian families, neurodivergent behaviours become difficult to describe, with behaviours remaining open to stigmatisation; signs of weakness, laziness, or lack of self-control. As a result of this, ADHD is commonly misunderstood as a behavioural failing or character flaw rather than a medical issue.

Notably, these findings show that narratives about mental health must be 'de-Westernised' without losing their clinical validity. The experiences of the participants suggest the need for culturally responsive frameworks that are sensitive to cultural and familial contexts and can affirm neurodivergent identities. Phenomenological research of this kind is critically needed to shed light on the underlying conflicts and lived experiences, as well as guide the creation of focused psychoeducational materials through cooperative working groups. Asian women in Aotearoa/New Zealand will continue to bear the emotional and intellectual weight of bridging this gap on their own until such frameworks are more broadly integrated into everyday life.

4.4.2 Post-Diagnosis Identity Reconstruction

This theme explores how participants' identity reconstruction was prompted after being diagnosed with ADHD as adults. Many participants saw the diagnosis as a pivotal moment that changed their previously pathologised views of themselves, which were frequently influenced by internalised stigma, societal silence, and failure-attributable misperceptions, into a more sympathetic and cohesive recognition of their neurodivergence. The diagnosis provided individuals with emotional comfort, recognition, and a framework to recontextualise lifelong challenges rather than undermining their sense of self. The diagnostic

label served as both an explanatory tool and a stimulus for self-acceptance, even though empowerment was defined as continuous and non-linear.

Affirmation of Identity. This subtheme explores the relief, validation, and rise in self-worth participants experienced after being diagnosed with ADHD. The diagnosis provided a much-needed explanatory framework for many, helping to reframe lifelong challenges, from issues with organisation and focus to emotional control and academic performance, as characteristics associated with a neurodevelopmental disorder rather than as personal shortcomings. Participants' self-perceptions appeared to shift as a result of this reframing, which provided them with a more sympathetic and less pathologising perspective on their past and current experiences. The diagnosis was perceived as a psychological turning point, as evidenced by several participants' descriptions of instantaneous and intense relief.

> *Oh, man. I felt so relieved.* (Participant A)
>
> *Oh, yeah. For the first week, I was super relieved.* (Participant C)

These responses highlight how much internal strain was relieved by a formal explanation and the emotional burden that many participants had been carrying before being diagnosed, frequently in silence. Most participants accepted the diagnosis as a validating explanation of their personal experiences rather than feeling constrained by a label.

> *I don't think I had any kind of negative feelings about it. I think it was more positive, especially because I kind of sought it out as well. It just like kind of affirmed that a lot of the things that I struggled with it wasn't because I can't do things properly or something, you know?* (Participant B)

Participant B emphasises how the diagnostic procedure was both empowering and affirming, providing a reinterpretation that broke a previously internalised narrative of failure or incapacity. Even interviewees who were still dealing with the emotional consequences echoed this tendency of rephrasing personal struggles.

> *Mixed picture. There was relief. I wouldn't go so far as to say that I've been, that I felt, say, self-empowered or anything yet. I think I'm getting towards that stage.* (Participant D)

The intricacy of post-diagnostic adjustment is encapsulated by Participant D, who acknowledges the advantages of relaxation and clarity while also realising that empowerment

is a continuous process rather than a quick fix. Participant E elaborated on this notion, characterising the diagnosis as a shift from internalised self-blame to self-awareness:

> *My self-worth was already awful before the diagnosis, so when I got it, it was more so, "Oh damn, I have a reason for why I'm like this and not that, and it's not because I'm just a lazy failure of a burden on this family…despite what I've said, I do believe it had a positive impact since I had a reason for why I was like this, why I struggled so much.* (Participant E)

For some who had found it challenging to balance their skills with social or academic expectations, the diagnosis provided an emotional and cognitive closure. Several individuals discussed how receiving the diagnosis enabled them to view themselves more compassionately and release long-standing shame.

> *It took a while to accept, but now that I accepted it, and as an adult, I've found my community a bit more. I think it's definitely helped. It's kind of just, "Oh, I'm not cursed; I just have this.* (Participant F)

This claim illustrates how ongoing identity work and diagnostic affirmation can coexist. Participant F's choice of the word *"cursed"* illustrates how deeply embedded negative self-concepts, influenced by cultural and familial norms, had become before diagnosis. These difficulties persisted after receiving an ADHD diagnosis, but it signified the start of a journey to rebuild one's identity through identification with others like themselves (Asian and neurodivergent communities), hinting at the need for connections outside one's family for validation and support.

For this study's participants, receiving an ADHD diagnosis served as a crucial moment of validation, providing a framework that reframed ingrained feelings of inadequacy. The diagnosis helped individuals understand their prior challenges through a neurodevelopmental perspective, frequently substituting self-compassion for self-blame rather than weakening their sense of self. Even though the post-diagnostic adjustment process was complex and continuous, it was the first step towards identity reconstruction for many people as they moved from internalised deficit-based thinking to a more accepting and powerful self-concept.

Internalised Stigma & Reframing Self-Perception. Along with relief, participants often talked about how, in the absence of a diagnosis, their self-perceptions had been

influenced by internalised views about failure, lack of discipline, laziness, or self-stigma. The internal effects of culture and personal misunderstanding were apparent, although outward or enacted stigma was not a recurring topic.

> *I was like, oh, you know, like the words 'lazy' and 'not trying.'* (Participant A)
>
> *I thought it would give me a new lease on my life. With an official diagnosis and some medication, it'd make me more competent, more intelligent, because I considered myself lazy, messy, stupid, and a lot of other terrible things growing up.* (Participant E)

Such claims demonstrate how difficulties connected to ADHD were formerly perceived via a moral prism, which resulted in self-loathing rather than comprehension. As a result, the diagnosis helped participants reframe their past with greater compassion and less blame by uprooting these narratives and introducing a medicalised perspective. However, this reframing process was accompanied by resistance or ambivalence for some participants.

Concerned that the diagnosis would turn into *"another label,"* Participant B suggested that acceptance and scepticism would need to be continuously negotiated.

> *I guess, the whole idea of it being like another label.* (Participant B)

Similarly, Participant D alluded to the liminality of post-diagnosis identity integration when she talked *about "getting to that other stage"*:

> *Getting to that other stage, that ideal stage of feeling more like it's just a label that helps me understand myself.* (Participant D)

Even though the majority of participants made progress in incorporating common understandings of ADHD into their identities, it still took much emotional work to overcome internalised stigma, primarily when it was influenced by cultural or familial silence. Participant F explained this complexity by relating her own challenges recognising neurodiversity to intergenerational avoidance and shame:

> *I definitely struggle with it because I was like, "Oh, how could I be this?… I still do have mental breakdowns where I'm just like, "Oh, why am I like this? This sucks."…I think a lot of that shame also comes a little bit from like, you know, especially at home, how you're raised, and I realised that, I guess, part of the reason why my mum and maybe her generation feels a lot of shame around these topics is that there's definitely a lot of not knowing and then being afraid of the unknown, but that also*

turns into a feedback loop, like shame something and we don't treat it. It just gets worse. It doesn't like to disappear. (Participant F)

Participant F's observation illustrates how cultural silences surrounding mental health actively perpetuate cycles of shame and misunderstanding, which people must then endeavour to break and reverse rather than merely obscure facts. In this situation, receiving an ADHD diagnosis becomes a cultural act of resistance as much as a personal revelation.

Participants viewed their ADHD diagnosis as a significant confirmation of who they were rather than as a danger to their identity. Being diagnosed brought about a significant change, enabling individuals to reinterpret their lives with greater clarity, self-compassion, and hope, even as self-stigma persisted and empowerment remained a continuous effort. The transforming power of diagnosis is reflected in this subject, especially for those whose lived experiences of neurodivergence have long been ignored, misinterpreted, or made invisible in mainstream and cultural discourses.

4.5 Present

Participants in the current stage of their ADHD journeys show a growing and expanding comprehension of what it means to live with ADHD that goes beyond widely held preconceptions. By embracing the variety and diversity of ADHD experiences, especially in connection to gender, culture, and identity, their developing narratives challenge limited, hyperactivity-focused notions. This section looks at how participants voluntarily reframe their perceptions of ADHD to consider symptoms like inattention, executive dysfunction, and trouble regulating their emotions. It also emphasises how this broadened viewpoint helps people to challenge prevailing cultural narratives and diagnostic presumptions, leading to a more complex self-awareness. Through these contemplations, participants not only reinterpret their own relationship with ADHD, but they also start to challenge how society views neurodivergent experiences in their various cultural contexts.

4.5.1 Identity, Isolation, & Representation

In order to navigate a challenging environment of social alienation, changing self-perception, and cultural invisibility, this section examines how participants came to reframe

and recontextualise their ADHD identities in the present, months or years after diagnosis. Many participants gained a more expansive and individualised perspective of ADHD after receiving their diagnosis, challenging prevailing narratives about the disorder, especially those based on Western, male-centric, or hyperactivity-focused stereotypes. However, exterior seclusion frequently accompanied this inward lucidity. Participants, who were young Asian women in Aotearoa/New Zealand, spoke of the startling lack of community spaces and representation that could validate or mirror their lived experiences. The stories in this area shed light on the emotional and cognitive work required to develop a cohesive sense of neurodivergent identity, as well as the larger structural silences that make that process isolated, disjointed, and frequently invisible. When taken as a whole, these stories provide light on the conflict between the constant pursuit of societal and cultural acceptance and personal self-acceptance.

Expanding the ADHD Narrative. Following their diagnosis, participants gained a more thorough and nuanced understanding of ADHD as a diverse, complicated neurodevelopmental condition that goes much beyond the widely accepted hyperactive stereotype. This change in perspective was noteworthy because many participants realised that symptoms like executive dysfunction, inattention, and emotional regulation issues were important components of their experience with ADHD rather than just the hyperactive behaviours that are frequently depicted in popular culture.

A statement made by Participant B, *"It can look differently in people, but this is what it looks like for me,"* emphasises how diverse ADHD presentations can be and how crucial personal experiences are in defining the condition. This customisation highlights the shortcomings of a 'one size fits all' approach to understanding ADHD. It marks a shift away from strict diagnostic preconceptions toward an appreciation of the disorder's varied presentations.

Similarly, Participant C's explanation frames ADHD as a struggle with regulation, which shows up as difficulties maintaining focus or as appearing *"spacey"* or *"daydreaming"* rather than just as an inability to concentrate or remain still.

> *ADHD is a condition where you have difficulty with regulating, so controlling, rather than having no focus or not being able to sit still, so it's just finding it harder to stay*

> *focused or on topic, or sometimes doing things that kind of look like you're maybe daydreaming or a little bit spacey.* (Participant C)

By highlighting the cognitive and emotional dysregulation that is frequently overlooked or misinterpreted, this realisation contradicts the traditional hyperactivity-centric narrative. Additionally, the participant's wording emphasises that symptoms of ADHD might be subtle and often misunderstood by others, evoking an internal experience that may not be immediately apparent.

By discussing the variety of ADHD subtypes (combined, inattentive, hyperactive) as well as the challenges with emotional control that come with the 'disorder', Participant F counters the societal and medical propensity to reduce ADHD to observable hyperactivity by dispelling common misconceptions, such as *"people think that ADHD is you can't sit still, but it's like more than that."*

> *[I] just feel like it's more than just not being able to sit still. It's also like your emotional regulation, other things like that.* (Participant F)

The inclusion of emotional control as a primary symptom highlights the wider, frequently disregarded facets of ADHD that impact everyday functioning and overall health.

One participant reported a better understanding of how these characteristics were entwined with their sense of self, going beyond simply acknowledging the diverse symptomatology of ADHD. Participant E captured this internal conflict:

> *ADHD is so harsh. It's made my life more difficult than it would've been without it. But at the same time, these symptoms are so ingrained in me that I wonder how much of myself would exist without them. If you took away these symptoms that continuously disrupt my life yet have been integrated into my personality, how much of me is still left?* (Participant E)

This quotation effectively captures the emotional complexities of diagnosis, both as a reinterpretation of identity and as a framework for comprehending prior difficulties. Participant E has a profound ambivalence with separating the disorder from the individual, even though she realises the disruptive impact of ADHD. This conflict highlights a larger issue in the data, which is that for some people, getting a diagnosis raised existential concerns about authenticity and selfhood in addition to explaining previous struggles. This viewpoint suggests a more comprehensive understanding of neurodivergence as something

that both shapes and is shaped by personal identity throughout time instead of seeing ADHD as an external, resolvable issue.

Over time, several individuals began to reframe their ADHD as a distinct method of processing the world, one that may, in the appropriate setting, stimulate creativity, intuition, and emotional depth rather than as a deficit. They began to view their challenges as being compounded by inflexible systems and unfulfilled requirements rather than as inherent defects, which was a significant turning point in their meaning-making process. However, they had few points of reference to support this more empowered self-understanding, as there were no positive cultural narratives to draw upon. Despite their strength, their newfound understanding frequently clashed with prevailing ideologies that persisted in pathologising or erasing their different experiences.

Collectively, these narratives demonstrate the participants' increasing recognition of the shortcomings of popular narratives on ADHD, especially concerning gender, culture and presentation. When participants recognised how cultural norms had previously masked their experiences, they felt both validated and frustrated by the underrepresentation of women and non-hyperactive types. In addition to helping them comprehend their own difficulties, this realisation put them in a position to question and broaden society's perceptions of ADHD as unofficial advocates. The participants' growing understanding of ADHD shows a significant departure from preconceived notions and a move towards appreciating the disorder's diversity and complexity. Their experiences highlight how crucial it is to acknowledge ADHD as a complex neurological difference that presents differently in every person, which calls for more inclusive and sophisticated professional and cultural discourses.

Belonging & Isolation. This subtheme highlights the participants' feelings of loneliness resulting from the lack of communal spaces and culturally relevant neurodivergent role models. Participants placed a strong focus on academic achievement, behavioural conformity, and emotional control, as well as on the mainstream discourse surrounding ADHD, which frequently revolves around Western narratives. A perceived contradiction between their diagnosis and their cultural identity was exacerbated by the lack of visibility of neurodivergent Asian personalities in the media and local communities. Participants found it difficult to reconcile being Asian and having ADHD, as if the two identities could not coexist, given the absence of role models or environments that represented their actual

experiences. However, some found new frames that embraced characteristics like hyperfocus, inventiveness, and emotional sensitivity, not as deficiencies but as manifestations of cognitive difference, when they started to interact more closely with neurodivergent groups and language. Even if these narratives were still rare in their cultural contexts, this increasing recognition provided glimmers of pride and self-acceptance.

Of the participants, five out of six reported they did not yet know any other Asian women with ADHD. Feelings of estrangement were heightened by this absence, which also cast doubt on the validity of their diagnosis. For many, diagnosis and self-understanding were hindered by the absence of identifiable, relevant individuals; there was no common language, cultural validation, or community support online or in person. The participants experienced both interpersonal and epistemological isolation: despite being aware of their identity as neurodivergent individuals, they felt disconnected from their environment and as though their presence was not relevant to either mainstream or cultural narratives. Participant A's reflection encapsulates this stark absence:

> *My whole time being at [redacted] and seeing other clients in the waiting room – no Asians!* (Participant A)

She frequently used neurodivergent services, but she had never met another Asian client, which confirmed the internalised belief that 'people like her' do not have ADHD or, at the very least, do not seek help for it. She seems resigned to this invisibility, as seen by her statement that she was *"not surprised"* by the dearth of Asian participation in her arts and crafts club for neurodivergent individuals. It implies that the lack of representation and silence is so ingrained that it is accepted as the rule rather than the exception.

In a similar vein, Participant B said that she was the only Asian woman in a neurodivergent peer support group at her university, where the majority of participants were men. She regarded the group as homogeneous and male-dominated, except for one Asian facilitator.

> *One of the facilitators, he was Asian. Also, most of the students who went were male; one of the regular students who went was a female student.* (Participant B)

This statement highlights yet another aspect of intersectional invisibility: Asian women, in particular, were virtually non-existent, in addition to Asian people in general. Even in environments designed to promote support and community, participants found it more

challenging to feel seen entirely due to the absence of gendered and cultural resonance in these areas.

A slightly different viewpoint, based on a partial familial tie, was presented by Participant D. Their bond was built on their shared experience since her older sister was also diagnosed with ADHD:

> *Most of my engagement will be with my eldest sister. A lot of our catch-ups tend to be around our shared experience…what we've been thinking about, what we've been learning about, what we've been feeling.* (Participant D)

She did, however, mention a persistent reluctance to engage more widely with neurodivergent populations. Her hesitation may demonstrate the pervasiveness of the cultural scripts of self-containment and silence: *"I guess that's probably because I'm still in that stage of being a bit more private or trying to figure things out for myself."* Even though her sister's presence provided a unique opportunity for cultural and experiential mirroring, Participant D was wary of going beyond the security of that bond. It demonstrates how a sense of belonging can exist for some people but is nonetheless conditional, private, constrained, and brittle.

According to participants C, E, and F, none of the other Asians they knew were neurodivergent. An already prevalent sense of marginality, residing on the periphery of both neurodivergent and Asian spaces, was reinforced by their lack of community. For them, being neurodivergent felt culturally incongruent or even unattainable, and self-advocacy and self-acceptance had to take place in a setting where they could not see themselves reflected beyond flimsy and passing posts within social media spaces. Given how much of their cultural upbringing was centred on community and familial connectedness, this distance was especially difficult for them because they were alone in this important area of their lives.

When combined, these stories highlight how underrepresentation, silence, and invisibility affect cultural and social membership. Many people experienced emotional labour, internal conflict, and the gradual creation of an identity without a clear pattern as they travelled the path to self-acceptance. Participants began to doubt the validity and authenticity of their experiences due to the lack of community and role models. When representation was eventually experienced, it frequently marked a turning point for the participants, allowing them to see themselves not as anomalies but rather as a part of a larger, albeit still

developing, story of neurodivergent Asian identity. The journey mainly remained solitary until then.

4.6 Summary of Analysis

The experiences of neurodivergent (ADHD) young Asian women in Aotearoa/New Zealand were explored in this chapter, covering four periods: before the diagnosis, during the diagnostic process, after the diagnosis, and reflections in the present. Guided by IPA, which allows for phenomenological meaning-making to unfold chronologically, this framework enabled the acquisition of a sophisticated understanding of how participants interpreted their experiences over time. In addition to complicated family and cultural dynamics characterised by maternal dominance, low mental health literacy, and epistemic dissonance between cultural values and neurodivergent identities, participants' early perceptions of ADHD and the effects of the COVID-19 pandemic influenced their paths to self-understanding during the pre-diagnosis phase. Curiosity satiated through research efforts led to self-understanding. However, this was made more difficult after diagnosis by internalised academic conformity, and family dynamics included intergenerational awareness shifts as well as peer and cultural comparison. In addition to a process of identity reconstruction marked by both affirmation and the reframing of internalised stigma, the post-diagnosis phase also demonstrated changing parental attitudes and continuous navigating of cultural narratives. Participants are now actively advancing the story of ADHD in their communities while striking a careful balance between feelings of isolation and belonging. These results underline the significance of culturally sensitive approaches to support and advocacy for young Asian women with ADHD in New Zealand by highlighting the complex interactions between culture, identity, and neurodivergence.

Chapter 5: Discussion

This study aimed to explore the lived experiences of neurodivergent young Asian women in Aotearoa/New Zealand with ADHD, with an emphasis on how individuals navigate their ADHD identity within overlapping cultural, familial, and societal settings. In light of the research objectives, theoretical frameworks, and the current body of literature, this chapter explains and situates the findings from the preceding chapter in context. To better understand how neurodivergent (ADHD) young Asian women in Aotearoa/New Zealand navigate their diagnosis and identity in the context of overlapping sociocultural landscapes, this study used IPA.

Five interconnected superordinate themes emerged from the research, each with subtle subthemes that collectively provide insight into the participants' changing self-perceptions, neurodivergence, and cultural positioning. This chapter begins with a summary of the findings and further explores these in light of existing research, considering their implications.

5.1 Summary of Findings

The findings of this study show that participants' understanding and navigating of their ADHD diagnosis was a multi-layered and intricate process. A variety of factors influenced their journeys, such as internalised academic expectations, early experiences of difference exacerbated by the COVID-19 pandemic, and the unstated societal and familial conventions surrounding mental health. As a researcher with lived experience of being diagnosed with ADHD in similar cultural and familial circumstances, I acknowledge that my personal insights and positionality have affected how these narratives were read and examined. Although receiving a formal diagnosis was a significant turning point for the participants, it also marked the beginning of a more thorough identity reconstruction process that required participants to reflect on and reframe their prior experiences. As individuals navigated their neurodivergence within the framework of familial ties and broader cultural norms, this process was both relational and personal. Participants struggled with feelings of isolation and underrepresentation in addition to times of self-awareness and empowerment, highlighting the significance of visibility, community, and more inclusive cultural narratives surrounding ADHD. The implications of these findings are also discussed in this chapter,

highlighting how participants' experiences both confirm and challenge preexisting understandings by situating these findings within the context of critical research on cultural identity, neurodiversity, and stigma. In doing so, I contend that a particularly complex identity journey, one characterised by silence, resistance, and resilience, is produced by the combination of gendered cultural norms, delayed diagnosis, and low mental health literacy.

This interpretive framework honours the dual hermeneutic at the core of IPA by attempting to both describe the experiences of the participants and investigate how they interpreted these experiences within specific historical, family, and sociocultural contexts. Identity is shown to be malleable and constantly rebuilt across all themes, influenced by internalised stigma, a diagnostic label, and social and cultural norms. Each theme and its subthemes are presented in turn in the analysis that follows, with links to current theoretical and empirical research to enhance comprehension of how neurodivergence manifests and is experienced at the intersection of diagnosis, gender, and culture, which are discussed in later sections.

5.1.1 Shifting Realities: How Pressure & Disconnection Shaped Early Self-Understanding

The journey to understanding ADHD frequently began in a state of misrecognition, influenced by prevailing cultural narratives and educational settings that highlighted behavioural conformity and academic achievement. Early impressions of ADHD among research participants were characterised by absence or uncertainty, which was exacerbated by internalised scholastic pressure and a dearth of easily understandable frameworks for neurodivergence. With a special focus on the growing consequences of internal academic conformity and the reflective space established during the COVID-19 pandemic, this section examines how these young women made meaning of their experiences before diagnosis and during their diagnostic period.

Prior to being diagnosed with ADHD, several participants reported a protracted period of confusion or misrecognition during which the symptoms they encountered were either pathologised, normalised, or moralised by culturally driven expectations around behavioural control and academic success. Behaviours linked to ADHD, including emotional dysregulation or inattention, are frequently viewed as reflections of poor discipline, laziness, or weak character rather than neurodivergence in various Asian cultural contexts (Kim et al.,

2011). Intergenerational values that emphasise academic success, self-control, and emotional restraint as markers of respectability and family honour are intricately linked to these attitudes (Hwang & Goto, 2008). As a result, participants internalised these expectations from a young age and frequently blamed themselves for their perceived organisational and academic failures rather than acknowledging that these were signs of a neurodevelopmental disorder. This is in line with earlier studies that found stigma and familial silence can cause Asian teenagers, especially females, to put off getting treatment or acknowledging mental health issues (Sue & Sue, 2016; Yeh & Inose, 2002).

Several individuals reported that the COVID-19 pandemic brought about an unexpected shift in their self-perception. Increased isolation and the disruption of academic settings and school routines provide a unique chance for introspection. Many people became more aware of their issues with motivation, focus, and executive functioning when there were no outside structures present, which caused them to reevaluate their preconceived notions about themselves (Ho et al., 2020; Lee, 2020). This pivotal moment is consistent with what scholars often refer to as 'delayed exposure' to neurodivergence, in which people only realise they have ADHD after they are exposed to terminology, frameworks, or periods that permit reassessment (Long & Coats, 2022). Disrupting internalised cultural myths and forcing a re-examination of identity and difference, the pandemic was both a catastrophe and a moment of clarity for these young women.

Participants' delayed recognition of ADHD demonstrates the nuanced ways in which people construct their own identities through prevailing cultural, familial, and institutional narratives rather than merely reflecting a lack of diagnostic access. The twofold hermeneutic of IPA emphasises that participants interpret their experiences within frameworks that are mediated by social and cultural factors in addition to making sense of them (Smith et al., 2009). These young women's early self-concepts were significantly impacted by implicit expectations for academic success and emotional control, which were created by parenting styles based on filial piety and East Asian cultural standards. For example, research in Malaysia has found a relationship between 'training' (guan) parenting and increased expectations for academic performance and compliance (Nainee et al., 2021). In contrast, Chao's (1994) work explains how guan emphasises parental control intended to teach discipline and achievement.

Furthermore, individuals from collectivist backgrounds often employ coping mechanisms that align with high parental expectations and the desire to fulfil perceived obligations, according to cross-cultural coping research (Heppner et al., 2012). The way this study's participants internalised responsibility and monitored emotional reactions was greatly influenced by these cultural scripts of duty and restraint, which were subtly ingrained in family structures and larger social discourses. Their internal conflicts and outward performances became discordant as a result, which strengthened an internalised sense of moral failure or inadequacy. Thus, the diagnosis of ADHD constituted a significant moment of narrative disruption, wherein experiences that were previously incoherent or morally charged were reconstructed via a neurodevelopmental lens, mainly when it was prompted during the pandemic's contemplative pause (Eatough & Smith, 2006). As a result of their roles as Asian women navigating the intersections of culture, gender, and neurodivergence in Aotearoa/New Zealand, this reconsideration marked the beginning of an ongoing reconstructive identity development process.

5.1.2 Between Expectation & Expression: Reframing Familial & Cultural Tensions

The participants' early conceptions of difference were shaped by their families' private and frequently unacknowledged cultural contexts rather than in a vacuum. This section looks into how individuals' experiences with ADHD were influenced by societal standards of success, mother influence, intergenerational dissonance, and familial silence on mental health. Significant epistemic tension arose from the absence of discussion surrounding emotional well-being, as well as implicit expectations of success and peer comparison, particularly when individuals began to doubt and re-examine these narratives after receiving a diagnosis.

Participants' experiences with ADHD were part of larger family dynamics that were marked by maternal authority, parental silence, and implicit expectations of behaviour, emotional control, and success. Open conversations regarding mental health are still uncommon in many Asian cultural contexts, where psychological difficulties are frequently viewed as personal issues or moral faults (Kim et al., 2011; Kuo et al., 2007). According to several participants, their mothers played a significant role in establishing these standards as emotional gatekeepers and enforcers of academic pressure. This is consistent with research

indicating that mothers in collectivist households may assume the role of cultural transmitters, promoting ideals of achievement, obedience, and selflessness that are passed down through generations (Chao, 1994).

In Asian families, the relationships between parents and children, especially between daughters and maternal figures, have a significant impact on identity and emotional development. Daughters often assume caregiving responsibilities within the family, particularly when mothers are experiencing emotional difficulties. This reinforces a sense of obligation and self-suppression (Leung et al., 2023). When mental health issues such as ADHD violate established family norms, maternal proximity can either be a source of emotional grounding or a source of conflict (Mazursky-Horowitz et al., 2015; Woods et al., 2019). Recent research indicates a growing trend towards greater emotional participation, particularly in diasporic families navigating cultural expectations across generations, despite paternal figures' historical positioning as providers or disciplinarians (Liu et al., 2022). In South Asian settings, it has been discovered that a father's presence can stabilise daughters during times of maternal grief or absence, fostering resilience and a stronger sense of self (Sharma & Natrajan-Tyagi, 2018). In the context of family duty, silence, and stigma, the emotional availability – or lack thereof – of maternal and paternal figures greatly influenced how many study participants perceived and dealt with their ADHD.

Epistemic dissonance, in which Western psychological explanations conflicted with cultural frameworks that support moral or spiritual interpretations of distress, exacerbated mental health illiteracy (Kirmayer, 2007). In addition to delaying participants' access to diagnosis, this dissonance influenced how their families responded to their ultimate disclosures, varying from silent indifference to outspoken denial or uneasiness. Managing ADHD in immigrant households frequently presented Asian women with difficult choices between maintaining family unity and pursuing personal recognition. According to research on acculturative family distancing, cultural expectations and intergenerational values increase the pressure to keep quiet about mental health issues. This dynamic results in emotional and relational strain due to cultural and communication gaps between generations (Chan et al., 2022; Yu et al., 2025). Similarly, research on Asian-American families has shown how cultural norms, parental stigma, and the fear of upsetting the peace can cause internal conflict in young people who have to balance their own psychological needs with expectations of loyalty to their family (Gao et al., 2024).

These experiences can be understood through IPA as meaning-making within complex, frequently contradictory social and familial structures. Instead of accepting cultural expectations passively, participants engaged with them reflexively, balancing internalised norms with developing self-awareness. In addition to understanding their families' responses as influenced by generational trauma, migration histories, and structural constraints, participants sought to make sense of emotionally complex situations, such as being reprimanded for 'laziness' or compared to neurotypical siblings, according to IPA's double hermeneutic (Eatough & Smith, 2008; Smith et al., 2009). For instance, several participants acknowledged that their parents' limited understanding of ADHD was a result of their limited upbringing rather than malice. Laungani (2007) refers to this interpretative approach as 'cultural embeddedness,' in which people situate their experiences within the larger historical and cultural narratives that influence their families. The intricacy of identity development is demonstrated by participants who simultaneously express empathy for their parents, especially their mothers, despite their dissatisfaction, as their neurodivergent self conflicts with inherited frameworks of duty, resilience, and silence. Through the experiences of young women with diagnosis and self-advocacy, these intergenerational conflicts highlight how cultural values are dynamic, negotiated, and occasionally renegotiated rather than being constant or oppressive.

5.1.3 Becoming Through Diagnosis: Reclaiming a Neurodivergent Identity

For many, getting a diagnosis was a turning point that led to a revaluation of long-standing personal struggles. This section looks at how participants rebuilt their identities after receiving a diagnosis, redefining previously internalised difficulties with focus, organisation, or emotional control as signs of ADHD rather than personal shortcomings. Although many felt relieved and validated, this approach also brought to light internalised stigma and ambivalence, illuminating the complexity of identity work at the nexus of neurodivergence, gender, and culture.

Receiving a formal diagnosed of ADHD as an adult sparked a period of intensive self-reflection and identity revision for research participants. Lifelong difficulties, especially those related to attention, emotional control, and academic consistency, were reframed as symptoms of a neurodevelopmental disorder rather than as personal shortcomings due to the

diagnosis' explanatory framework (Singh, 2011). Many participants felt reassured and validated by their diagnosis. This change in identity is comparable to what researchers discovered in a study on developmental disorders, where diagnostic labels helped coping, meaning-making, and connection to others with similar experiences (Werkhoven et al., 2021). Internalised stigma, however, frequently accompanied this, particularly when individuals thought back on years of being called emotionally unstable, sluggish, or noisy. These results are consistent with studies on the 'double stigma' that racialised people with mental illness, which shows that the weight of both mental health stigma and racial prejudice severely discourages seeking care and exacerbates psychological pain (Gary, 2005). Some participants were particularly concerned that, in family systems that associate hardship with resiliency and disability with shame, accepting their diagnosis would be interpreted as an excuse rather than an explanation. Therefore, the process of identity reconfiguration involved navigating conflicting discourses around selfhood, responsibility, and cultural acceptance in addition to personal insight.

According to IPA, the participants' post-diagnosis meaning-making demonstrates how selfhood is reconstituted in response to evolving societal narratives and new psychological information. Participants regarded diagnosis as a means of gaining a deeper understanding and reinterpreting past experiences rather than as a definitive endpoint. This aligns with IPA's focus on temporal reflexivity, which posits that people look back to understand who they are in the present (Smith et al., 2009). For instance, participants discussed reassessing early memories and reinterpreting actions that were previously viewed as 'lazy' or 'careless' as signs of unacknowledged neurodivergence. They began creating new narratives of acceptance and self-compassion through this hermeneutic process. Crucially, many participants reported feeling more connected and united, either through informal peer networks or online communities, what some academics call "counter-narratives" that challenge prevailing, deficit-based interpretations of ADHD (Kapp et al., 2013; Singer, 1999).

Additionally, this re-storying often occurred during tense or silent periods, particularly when individuals chose not to disclose their illness to their peers or family. In IPA, these silences are also significant because they show the points at which people cross social boundaries and decide to rebel or defend themselves (Smith et al., 2009). In the end, the diagnosis was a generative moment rather than a single turning point that allowed

participants to examine, validate, and occasionally lament facets of their identities that had previously been overlooked or misunderstood.

5.1.4 Carving Space for Difference: ADHD Within Family & Culture

After receiving their diagnosis, participants frequently had to explain and justify their ADHD in cultural and familial contexts where there was a lack of such terminology and comprehension. This section examines how individuals navigated their neurodivergent identities in various settings, including seeking acceptance from their parents, questioning conventional wisdom, and, in certain situations, observing a gradual shift in perception. These discussions illustrate the emotional effort required to balance societal norms with personal experience, as well as the fortitude necessary to claim one's identity.

Participants described the emotionally challenging process of negotiating ADHD in Asian family structures, which frequently value unity over individuality and silence over transparency. According to Kim et al. (2011), many individuals face their parents' initial denial, minimisation, or condemnation when disclosing their diagnosis. These reactions are based on cultural scripts that see mental health concerns as private or shameful. When participants actively shared information or imitated behavioural changes following diagnosis, some families did, however, eventually show cautious openness or developing acceptance. Through exposure, knowledge, and lived experience, traditional parenting values are selectively maintained, altered, or abandoned – an interactive process known as acculturation and enculturation – in immigrant families, which is reflected in this generational shift (Zhou & Gatewood, 2000).

Nevertheless, most participants felt as though they were continuously juggling two different worlds: Standing up for their needs while shielding their families from embarrassment or discomfort. These discussions highlight the cultural explanatory mismatch frequently documented in cross-cultural ADHD studies, where conventional wisdom regarding effort, discipline, and appropriate behaviour clashes with scientific knowledge, causing symptoms to be recognised and accepted later (Kirmayer, 2007). The participants' descriptions of limiting emotional expression or avoiding full disclosure in order to avoid conflict underscored the relational labour needed to manage stigma in close-knit, high-context family circumstances. This is consistent with research by Choi and Dancy (2009),

who found that in order to preserve family cohesion in high-context situations, Korean American families dealing with acculturative stress frequently repress emotional expression, particularly when discussing delicate subjects.

These results demonstrate how participants understand and reinterpret their roles within familial and cultural systems that defy easy dichotomies of acceptance or rejection, which is consistent with the IPA framework. Participants frequently described their experiences with empathy and ambivalence, describing both pleasant and confusing times in the same sentence rather than seeing parents as either unsupportive or supportive. This intricacy is consistent with IPA's focus on emotionally nuanced, context-specific meaning-making (Smith et al., 2009). In addition to what was said, participants also inferred meaning from nonverbal cues such as hesitations, silences, and indirect gestures. Even though formal interactions were avoided, one participant saw her mother's willingness to read resources about ADHD as a subtle kind of care. These complex interpretations are consistent with what Kirmayer (2007) refers to as culturally moulded idioms of support and distress, in which action rather than overt words convey meaning. In these situations, negotiating neurodivergence became less about 'educating' others and more about redefining the parameters of relational understanding, which involved adjusting expectations, managing disclosure, and resolving unresolved conflicts. Participants demonstrated through this continuous process how identity is co-constructed in a dynamic interaction with family relationships, cultural values, and personal development.

5.1.5 Belonging in Difference: Visibility, Community, & the Rewriting of Self

The final theme examined participants' reflections on visibility, belonging, and the broader societal conversation surrounding ADHD. This section examines how participants addressed underrepresentation and how some began to reevaluate what it meant to be Asian, female, and neurodivergent through diagnosis and community involvement. Their stories underscore the importance of participation in a broader, more inclusive discourse on neurodivergence alongside a deeper understanding.

The participants described the difficulties of fitting in with the prevalent narratives around ADHD, which are frequently created from a Western, male-centric, and white-centric perspective (Hinshaw & Ellison, 2016), for many Asian women's lack of visibility in

discussions of ADHD fuelled sentiments of exclusion and scepticism about the validity of their personal experiences. Internalised stigma was greatly strengthened by this representational void, which made participants wonder if their symptoms were due to 'ADHD enough' or just bad time management. According to research, women and girls with ADHD frequently go undiagnosed because of differences in presentation (e.g., inattentiveness instead of hyperactivity), which leads to internal self-doubt and misrecognition (Quinn & Madhoo, 2014). Several participants expressed disappointment at the scarcity of prominent individuals who represented their intersectional identities or provided culturally relevant resources. As a result, it was more challenging to feel seen, receive support, or access information. Broader social scripts that portray ADHD as a childhood condition or one linked to outward hyperactivity, characteristics that did not always correspond with participants' more internalised experiences, exacerbated this feeling of loneliness (Conrad & Bergey, 2014). Due to this, their attempts to explain neurodivergence were frequently influenced by the urge to defend rather than merely explain, which added to the constant conflict between societal plausibility and personal truth.

The stories of the participants, as viewed through the lens of IPA, reveal a dynamic process of reframing what ADHD can look like, particularly for young Asian women navigating the multicultural yet Eurocentric social landscape of Aotearoa/New Zealand. Instead of focusing on deficit-based models, their narratives emphasise emotional depth, cultural subtleties, and subdued forms of resistance. Through peer relationships, internet forums, and scholarly research, participants described creating counter-narratives – spaces where they could identify and validate experiences that had previously been written off. This aligns with the work of neurodivergent academics such as Singer (1999) and Kapp et al. (2013), who advocate for a shift away from pathologising language and toward frameworks that promote identity. Furthermore, many participants presented their self-advocacy as a political and cultural act, an effort to change how people see who should be seen, heard, and supported, in addition to reclaiming space for themselves. This narrative reconstruction process aligns with what Smith et al. (2009) refer to as a double hermeneutic, in which individuals both make sense of their experiences and contribute to broader cultural discussions. In the end, by broadening the definition of ADHD, participants are not only rewriting their narratives but also opposing prevailing epistemologies that make them invisible.

5.1.6 Summary of Key Themes

The five superordinate themes and their 14 subthemes collectively shed light on how young Asian women with ADHD navigate their identities in a variety of social, familial, and personal situations in Aotearoa/New Zealand. Participants' experiences show a dynamic, frequently contradictory journey of self-understanding and identity reconstruction, from early misconceptions and academic demands to post-diagnostic affirmation and ongoing conflicts within family and cultural institutions. These findings underscore the significance of intersecting factors in shaping how neurodivergence is perceived, communicated, and addressed, including gendered norms, cultural expectations, diagnostic narratives, and representational gaps. Participants actively interact with these factors in complex, emotionally compelling ways rather than passively receiving or resisting them, as seen by the interpretative lens of IPA. In the following section, the findings are linked to theoretical frameworks that aid in explaining the intricate interactions between culture, identity, and neurodivergence, thereby enhancing our comprehension of these meaning-making processes.

5.2 Link to Theoretical Frameworks

The results must be placed within a larger theoretical framework that takes into consideration the social and psychological mechanisms at work in order to interpret participants' experiences with ADHD diagnosis and identity in a meaningful way (Smith et al., 2009). Hermeneutic phenomenology, identity construction, and stigma theory are three interconnected frameworks that provide important insights into how young Asian women in Aotearoa/New Zealand navigate the cultural and psychological implications of neurodivergence. While identity construction theories (e.g., Jenkins, 2004; McAdams, 1997) shed light on how people socially and narratively construct a sense of self in relation to their surroundings, stigma theory, specifically, the idea of internalised stigma (Corrigan & Watson, 2002), examines how people come to adopt society's negative perceptions of their differences. These are complemented by an IPA hermeneutic orientation, which highlights the interpretative and dynamic character of meaning-making through the hermeneutic circle (Smith et al., 2009). These viewpoints collectively provide the conceptual foundation for

understanding how the participant's perceptions of their experiences before and after diagnosis changed over time and how their sense of identity within culturally specific frameworks influenced and continue to influence these interpretations.

5.2.1 Stigma Theory & Rejection Sensitivity

The majority of participants in this study characterised their ADHD diagnosis as a moment of relief and validation rather than anguish, even though theories of internalised stigma frequently highlight shame, self-blame, or a diminished sense of self following psychiatric diagnosis (Corrigan & Watson, 2002). For these young Asian women, a formal diagnosis provided a context for understanding long-standing issues, especially those related to academic pressure, focus, and emotional control. Post-diagnosis, all of the participants expressed a sense of self-compassion rather than internalising negative stereotypes, stating that the diagnosis enabled them to reframe earlier events as manifestations of undiagnosed neurodivergence rather than as personal failures. The diagnosis was a watershed in their identity development, as it validated their struggles, upended negative self-narratives, and provided them with a mechanism to express their demands. By demonstrating that, in particular cultural contexts, formal recognition can be empowering, especially when it fills a void left by years of misunderstanding, comparison, and unmet support, this research challenges prevalent deficit-based understandings of diagnostic labelling (Hinshaw & Stier, 2008). The persisting complications of stigma and self-acceptance were nevertheless reflected in participants' continuous attempts to negotiate cultural expectations and familial perceptions, even though relief was the most common first response.

The concept of rejection sensitivity, a heightened propensity to anxiously expect, perceive, and react passionately to rejection, can be taken into consideration to gain a deeper understanding of participants' emotional landscapes (Downey & Feldman, 1996). Individuals with ADHD frequently report feeling more sensitive to rejection, which can lead to emotional dysregulation and relationship problems (Bunford et al., 2018). This sensitivity is especially relevant for women with ADHD, who often have higher levels of social self-consciousness, internalised criticism, and heightened vulnerability to perceived rejection. There are gendered disparities in peer experiences and emotional discomfort, as evidenced by empirical research showing that females with ADHD frequently report more severe negative social preference

and internalising symptoms than boys with ADHD (Becker et al., 2013). According to Beheshti et al. (2020), individuals with ADHD, particularly women, exhibit clinically substantial levels of emotional dysregulation, which is typified by abrupt mood swings, strong adverse emotional reactions, and trouble regaining emotional baseline. This reality has a significant impact on interpersonal relationships and emotional well-being in familial and cultural contexts. These relationships can be particularly delicate in collectivist cultural contexts, where academic achievement, emotional control, and familial loyalty are highly prized.

The ADHD diagnosis provided participants in this study with a sense of personal validation, but it also carried the potential of upsetting family harmony or attracting criticism. Feelings of loneliness and the need for self-monitoring may have resulted from participants' increased emotional vigilance due to the possibility that family members might misrecognize or downplay their involvement. Therefore, rejection sensitivity provides a valuable framework for comprehending the emotional labour required to manage neurodivergence within cultural and familial norms.

5.2.2 The Narrative Construction of Identity

The results also highlight the dynamic process of identity building, in which individuals continuously contested their identities in light of their experiences, cultural background, and diagnostic classifications. Identity is shaped by continuous interactions with relationships, language, and social systems rather than being fixed (Gergen, 1991; Jenkins, 2004). The participants' re-examination of past life events after receiving an ADHD diagnosis challenged preconceived notions that they were merely 'lazy,' 'bad at time management,' or 'not trying hard enough.' This procedure reflects what McAdams (1997) refers to as the narrative construction of identity, in which people create cohesive narratives about themselves to make sense of their situations. Many, however, felt that adopting a neurodivergent identity was dangerous or culturally inconsistent because this rebuilding took place in conflict with prevailing cultural norms, such as filial piety, perfectionism, and emotional reserve. As a result, participants had to contend with the challenge of integrating this new identity into a cultural framework that failed to accommodate neurodiversity. Their

observations demonstrate that identity is a relational and personal activity influenced by the definitions given to concepts such as belonging, difference, and diagnosis.

5.2.3 The Hermeneutic Process

The hermeneutic process, a fundamental principle of IPA that emphasises meaning-making as a dynamic, circular activity, is integral to this study. According to the hermeneutic circle, people interpret their experiences by alternating between the parts and the whole – reassessing specific events in the context of their larger life narratives and vice versa (Smith et al., 2009). To make sense of their ADHD diagnosis retrospectively, participants described this process. Many of the participants viewed childhood habits, academic difficulties, or emotional management problems as previously unidentified signs of neurodivergence rather than personal shortcomings. This change in interpretation often occurred gradually and was influenced by peer or professional interactions, diagnostic tests, and exposure to internet content. The double hermeneutic, essential to IPA, was highlighted by the researcher's attempt to understand how participants make sense of their lives while acknowledging that this meaning-making is always situated and impacted by context. As a result, the researcher shared a variety of cultural and neurodivergent identities with participants; this procedure also necessitated a continuous reflexive attitude. This insider positionality required rigorous reflexivity to separate participants' meanings from personal projections, even though it promoted a deeper level of trust and empathy during interviews. The approach recognised that understanding was co-constructed through a dynamic interplay between participant narratives and the researcher's lived and academic lens. Instead of aiming for objective detachment, it welcomed the interpretative nature of qualitative enquiry. The narratives of the participants are revealed through this hermeneutic lens as dynamic accounts that are continually updated in response to shifting relationships, cultural discourses, and evolving knowledge.

5.2.4 Summary of Theoretical Frameworks

Overall, the participants' lived experiences demonstrate how their cultural background, evolving self-construction, and diagnostic recognition interact in a complex

manner. The participants' overwhelming response of relief challenges deficit-based assumptions and emphasises the empowering potential of diagnostic clarity, especially when it breaks years of internalised misunderstanding, even though stigma theory offers a helpful lens to understand the potential for shame and marginalisation following an ADHD diagnosis. Despite negotiating societal narratives that frequently opposed such reinterpretations, identity construction theories show how these young Asian women deliberately re-authored their life stories, shifting from internalised blame towards self-compassion and legitimacy. According to hermeneutic theory, their stories reveal a continuous process of meaning-making, in which prior experiences are re-examined and reinterpreted in light of new information and social positioning. Through the integration of these theoretical viewpoints, this study emphasises the significance of identity-affirming, culturally contextualised approaches to neurodivergence and the usefulness of IPA in capturing the interpretative, fluid nature of how people come to understand and express who they are.

5.3 Implications

The study's conclusions have important ramifications for future research, clinical practice, education, and policy. This study emphasises how overlapping cultural, family and social factors create experiences of diagnosis, identity, and stigma by elevating the voices of neurodivergent young Asian women in Aotearoa/New Zealand. These ramifications highlight how urgently culturally sensitive methods of identifying and supporting ADHD are needed in the medical field as well as elsewhere. Additionally, they demand more representation, inclusive diagnostic procedures, and community education that recognises and tackles this marginalised group's particular difficulties.

5.3.1 Family & Intergenerational Support

The experiences of young Asian women navigating neurodivergence in Aotearoa/New Zealand were found to be significantly influenced by family and intergenerational support. According to the participants' narratives, their sense of self, access to support, and ongoing well-being were predominantly shaped by their families' responses, which ranged from

denial and minimisation to progressive acceptance. Family variables are thought to play a role in ADHD in both direct etiological ways and as significant moderators and mediators of treatment effects and child outcomes (Johnston & Chronis-Tuscano, 2015).

For neurodivergent young Asian women, family and intergenerational support are crucial in determining their mental health outcomes, especially when dealing with an ADHD diagnosis. Due to cultural attitudes that portray behavioural problems as moral faults or the result of inadequate discipline, initial family reactions are frequently characterised by resistance or denial (Lee, 2018). According to Yang et al. (2007), mental health is a stigmatised and frequently suppressed topic in many Asian households, where worries about upholding one's reputation and family honour take precedence over emotional expression or psychological care. For those whose difficulties are misinterpreted or disregarded, this can result in emotional invalidation and social exclusion. This problem is exacerbated by a lack of culturally relevant psychoeducation, which narrows parents' knowledge of ADHD and perpetuates misconceptions or stereotypes (Gopalkrishnan, 2018; Kirmayer, 2001). Nonetheless, some participants reported a gradual change in their families' opinions, consistent with more substantial research on the role of biomedical validation in promoting acceptance (Quinn & Madhoo, 2014; Watters, 2010). This change is frequently sparked by noticeable improvements after treatment or easier access to information. Notwithstanding these changes, persistent impediments to intergenerational communication, such as language and cultural differences, can still make comprehension difficult (Cheung & Snowden, 1990). The internalisation of stigma, identity development, and the capacity to seek appropriate care can all be significantly impacted by family support, whether it is present or changing (Corrigan et al., 2009), underscoring the necessity of culturally aware, family-inclusive interventions.

5.3.2 Clinical & Diagnostic Practice

Both race and culture have been shown to influence perceptions regarding the behavioural symptomatology of ADHD (DuPaul et al., 2016). These impressions are important since clinicians tend to base their final evaluations on subjective behaviour ratings from patients, family members, educators, and other caregivers. Bias in cumulative reports resulting from subjective behavioural interpretations can impact treatment plans and patient

outcomes (Alvarado & Modesto-Lowe, 2017; Fadus et al., 2020). Additionally, a patient's or family's propensity to seek treatment for a particular issue may decrease when traditions, beliefs, and practices shape how that issue is defined (Gopalkrishnan, 2018). As a result, their response to a disorder such as ADHD may create further obstacles to the difficulties already faced in diagnosing and engaging patients (Morgan et al., 2013). Research indicates that cultural perceptions and sensitivities regarding ADHD can influence treatment outcomes, delay diagnosis, and influence the usage of stimulant medications. Various racial and ethnic groups, such as Asian, Middle Eastern, African, and South American, hold differing views on these topics (Morgan et al., 2013). In order to better understand the lived experiences of neurodivergent young Asian women in Aotearoa/New Zealand, such as internalised or enacted stigma, familial expectations, and culturally specific manifestations of ADHD, mental health professionals should create culturally sensitive diagnostic measures and psychoeducation.

Experts have developed several assessment tools to diagnose ADHD. By employing a variety of techniques and information sources gathered across various contexts, the limitations of each approach can be reduced (Shelton & Barkley, 1994). Clinical interviews, behaviour rating scale completion, direct behavioural observations, and psychological and psychoeducational evaluation are the primary techniques used to evaluate ADHD (Brown, 2005). We tend to concentrate on utilising behaviour rating scales first for two reasons: (1) they have been extensively studied and are a standard tool in the assessment of ADHD, and (2) there are no cross-cultural comparisons available for any other assessment approach (Reid, 1995). To effectively support people with ADHD from culturally diverse backgrounds, mental health professionals should make a conscious effort to educate themselves on cultural differences. Additionally, this cultural knowledge may help professionals better identify when a member of a culturally diverse group might require additional support (Cuffe et al., 1995).

The way that ADHD is identified, understood, and treated in families and healthcare systems is greatly influenced by cultural values and beliefs. Clinicians must, therefore, continue to be mindful of how cultural norms influence the manifestation of symptoms, the way people seek help, and their interpretation of diagnostic labels. Culturally inappropriate diagnostic procedures run the danger of causing misdiagnosis, treatment delays, and internalised stigma for young Asian women in Aotearoa/New Zealand with ADHD. This

emphasises the importance of culturally sensitive frameworks that go beyond 'one size fits all' assessments and consider various perspectives on support, behaviour, and identity.

5.3.3 Education & Awareness

Educational institutions should provide teachers with an appropriate level of training on how ADHD manifests in children from varied cultural backgrounds and differing genders, primarily inattentive or internalised symptoms that are frequently disregarded among Asians and females. For the most part, children spend their time in classrooms and other school settings where they are expected to follow the rules, act in a way that is acceptable to others, participate in educational activities, and not interfere with the learning or activities of other students who share their learning environment (Kleynhans, 2005). Since the classroom environment encourages children to behave in ways that are inconsistent with these defining symptoms, signs of ADHD are more noticeable in educational settings (Kos et al., 2006). Teachers are often the first to suspect ADHD in children (Tannock & Martinuseen, 2001). Furthermore, research indicates that they are the most frequently cited initial referral source, encouraging parents to have their children evaluated (Snider et al., 2003; Vereb & DiPerna, 2004).

It has been common practice to use teachers' recommendations for the evaluation of suspected ADHD as a predictor of a student's symptoms. They are regarded as one of the most crucial sources of information during the initial assessment of ADHD due to their everyday interactions with children and a variety of clinically relevant scenarios (Pelham et al., 1992). Moreover, in a study of 401 primary care paediatricians, Carey (1999) discovered that over half of them diagnosed ADHD based just on school reports provided by teachers. Children with ADHD may be over- or under-identified due to incomplete or inaccurate information on the disorder's characteristics (Scuitto & Feldhamer, 2005). Thus, as informants, teachers need to be provided with accurate information about the neurotype. They must be able to recognise the difference between normal childhood conduct and the symptoms of ADHD (Kauffman & Landrum, 2009; Sciutto et al., 2000). However, cultural and gendered preconceptions might influence teacher reports, which could result in girls with ADHD being under-identified since they are more likely to internalise symptoms and mask behaviours that hide their difficulties (Gershon, 2002; Quinn & Madhoo, 2014). Girls who

display inattentiveness without disruptive conduct are frequently disregarded since hyperactivity and externalising behaviours are more noticeable and typically linked to male presentations of ADHD (Hinshaw et al., 2006). This reinforces a gender bias in school-based identification techniques and causes significant delays in diagnosis and care for girls.

Research exploring teachers' awareness of ADHD has raised some concerns about whether or not they are knowledgeable enough about the neurotype to fulfil the significant and crucial roles they play in diagnosing, treating, and monitoring students with ADHD (Garcia, 2009; Perold et al., 2010). Dilaimi (2013) surveyed 84 primary school teachers in Aotearoa/New Zealand on the Knowledge of Attention Deficit Disorders Scale (KADDS). Results of Dilami's (2013) study show that teachers answered an average of 35% of questions correctly on the KADDS, most teachers had received no pre-service or in-service training about ADHD, and 90% of teachers wanted more training on ADHD. Primary teaching degrees are offered by a number of universities in Aotearoa/New Zealand. The University of Canterbury, Massey University, the University of Auckland, and the University of Otago are among the well-known institutions. In addition to postgraduate diplomas and other credentials, these universities usually provide primary-focused Bachelor of Education (Teaching) degrees. Though neurodiversity in the classroom is becoming more widely recognised, these teaching degrees usually do not require coursework on neurodevelopmental disorders such as ADHD. Teachers are key in recognising and assisting neurodivergent students; thus, they must possess a basic understanding of disorders such as ADHD in order to provide welcoming and encouraging learning environments.

The results of this research also encourage the development of culturally sensitive and respectful public education initiatives that raise awareness of neurodivergence and lessen stigma among Asian groups in Aotearoa/New Zealand. Early access to evaluation and support could have resulted in earlier diagnoses, according to some of the participants in this research, who expressed a strong desire for earlier interventions. They considered how this delay exacerbated long-term issues with identity, academic achievement, and mental health. Their stories illustrate the importance of identifying and supporting neurodivergent individuals at an early age to mitigate these challenges and promote more favourable developmental outcomes.

5.3.4 Policy & Representation

Policy and representation are essential factors in confronting the systemic obstacles encountered by young neurodivergent Asian women in Aotearoa/New Zealand. The New Zealand Disability Strategy and He Ara Oranga are two examples of policies that support equity, although they frequently do not specifically address the needs of neurodivergent Asian women. Both mental health and educational policies continue to underserve these populations in the absence of disaggregated data or frameworks that are culturally sensitive. Despite increased awareness of ADHD, the intertwining cultural, gendered, and neurodivergent experiences of this community are frequently overlooked by current mental health frameworks and policies (Cascio et al., 2021). Feelings of invisibility and exclusion are exacerbated by a lack of culturally sensitive treatment and visible representation in clinical, educational, and public discourse, which furthers the idea that their issues are uncommon or marginal (Chu & Sue, 2011). In addition to creating a sense of community, representation is crucial for influencing laws that take into account the realities faced by marginalised communities. Dominant frameworks risk pathologising behaviours without considering their cultural context if Asian voices are not actively included in the research, clinical training, and policy formulation (Kirmayer & Jarvis, 2019; Slobodin & Masalha, 2020). Therefore, increasing accessibility, lowering stigma, and fostering identity development among neurodivergent Asian youth depend on assuring meaningful representation and putting culturally sensitive mental health policies into place.

Policy interventions must acknowledge the intricate relationship between culture, identity, and neurodivergence rather than adopting a 'one size fits all' approach in order to help young neurodivergent Asian women in Aotearoa/New Zealand effectively. Current frameworks for mental health frequently reflect Eurocentric presumptions that ignore the particular needs of Asian groups, such as language barriers, intergenerational stigma, and culturally specific conceptions of disability and mental health (Gopalkrishnan, 2018; Kirmayer & Jarvis, 2019). The lack of culturally relevant representations of ADHD and visible role models made many study participants feel invisible and alone, underscoring the urgent need for public health initiatives and educational policies that consider the variety of ADHD experiences (Chu & Sue, 2011). Additionally, although educators and medical

professionals frequently play a significant role in the diagnostic process, Asian people may be misdiagnosed or underdiagnosed due to a lack of cultural competence and unconscious bias (DuPaul et al., 2016; Sleeter, 2012). Therefore, policy change should involve inclusive evaluation techniques that take into consideration how symptoms may be concealed or interpreted differently across cultures, as well as culturally sensitive training. Incorporating the perspectives of neurodivergent Asian individuals through co-design and participatory techniques will help ensure that interventions are not only successful but also equitable, demonstrating that representation must extend to the actual design of policies (Mitra, 2006). Last, lowering treatment barriers and developing culturally grounded support networks require increased investment in multilingual resources, community-based psychoeducation, and disaggregated ethnic data (Kokanović et al., 2013).

Ultimately, reevaluating mental health representation and policy from a culturally sensitive perspective is not just an issue of inclusivity but also an ethical requirement. Visibility, validation, and access to suitable help are intricately linked to larger systems of structural equity and cultural acknowledgement for neurodivergent Asian people in Aotearoa/New Zealand. This study highlights the significance of shifting from tokenistic diversity initiatives to systemic change that prioritises the perspectives and experiences of people at the intersections of gender, neurodivergence, and ethnicity. We may demolish exclusionary narratives and create more equitable, caring environments where neurodivergent identities are not only recognised but also validated by making investments in culturally grounded frameworks and representative leadership.

5.3.5 Research & Theory

This study emphasises the need for more culturally sensitive and intersectional research in the disciplines of neurodevelopment and psychology. It challenges dominant deficit-based and Western-centric paradigms that frequently overlook cultural differences in how ADHD is perceived, experienced, and supported by focusing on the lived experiences of neurodivergent young Asian women in Aotearoa/New Zealand. A more thorough investigation of identity, stigma, and meaning-making has been made possible by the application of IPA, which provides theoretically sound and contextually grounded findings. These results imply that psychological theories of neurodivergence, mental health stigma,

and identity development need to go beyond individualist models and include structural and societal factors. In doing so, this study contributes to more significant efforts to decolonise psychological frameworks and create theories that consider the various ways neurodivergent identities are formed across different cultural contexts (Kirmayer & Jarvis, 2019).

By focusing on the lived experiences of neurodivergent young Asian women in Aotearoa/New Zealand, voices that are frequently silenced within prevailing psychological paradigms, this research advances a more culturally situated understanding of ADHD. The study emphasises the dynamic and relational processes by which individuals make sense of their diagnoses, navigate cultural expectations, and reconstruct their identities using an interpretative phenomenological method. These results demonstrate how meaning-making is intricately intertwined with the intersection of culture, race, gender, and neurodivergence, extending beyond current theories of identity development (Hall et al., 2016; Phinney, 1990). The investigation highlights the significance of incorporating cultural and contextual diversity into understanding mental health and development and contradicts universalist assumptions in psychological theory. By doing so, it urges that current theoretical frameworks be expanded to incorporate more complex, intersectional, and decolonial viewpoints that more accurately capture the complexities of lived experience.

5.4 Suggestions for Future Research

This thesis highlights the need for further research on the intersectional experiences of young Asian women who are neurodivergent in Aotearoa/New Zealand. Although this study provides a preliminary understanding of the relationship between ADHD, cultural identity, and familial expectations, it also highlights topics that have not received sufficient attention in the existing literature. In addition to considering gender diversity and culturally based interventions, future research could build on these insights by addressing subgroup differences, intergenerational perspectives, changing identity trajectories, and institutional barriers. Research may refute deficit-oriented models and contribute to the development of inclusive, responsive policies and practices.

Subgroups, including Chinese, Indian, Korean, and Southeast Asian communities, have distinct cultural norms, beliefs, and migratory histories, which are often overlooked in current research that treats Asian populations as a monolith (Museus & Kiang, 2009). Future

studies should break down the data and investigate how these intra-ethnic variations affect people's experiences with ADHD, taking into consideration the influence of cultural taboos, language, religion, and community support. Such research would help prevent oversimplified assumptions that hinder effective treatment and/or support and foster more nuanced understandings of cultural differences in mental health (Kwak & Berry, 2001).

Future research should think about including the viewpoints of parents or carers because of the significant impact that familial and intergenerational dynamics have on forming attitudes about mental health and behaviours related to seeking treatment. Examining how older generations perceive or misperceive ADHD can help us understand how cultural norms around productivity, obedience, and family reputation affect how neurodivergence is recognised and handled (Kim et al., 1999; Kirmayer & Young, 1998). More comprehensive family-based therapies and psychoeducational techniques that cross-generational and cultural barriers may benefit from these insights (Ma, 2021).

Although identity is malleable and influenced by life transitions, the current study only documents a glimpse of identity building in young adulthood. To investigate how ADHD is managed through significant life events, such as post-secondary education, employment, and family formation, longitudinal research could track participants over time (Bussing et al., 2003). It would be possible to pinpoint areas where help is most needed by tracking these changes, which would provide a deeper understanding of how neurodivergence interacts with shifting cultural and gender identities (Phinney, 1990; Syed & Azmitia, 2008).

Access to mental health resources is significantly shaped by institutional and structural systems, which extend beyond the family and cultural milieu (Gee & Ford, 2011; Metzl & Hanze, 2014). Future studies should look at how immigration status, language challenges, and institutional bias impact Asian people with the diagnostic and treatment paths of ADHD. This includes awareness of how implicit biases influence underdiagnosis or misdiagnosis in the welfare, healthcare, and educational systems. By concentrating on these systemic elements, the discussion would move from personal experience to institutional responsibility (Gopalkrishnan, 2018).

As cisgendered young Asian women were the focus of this study, neurodivergent people who identify as transgender, non-binary, or gender diverse should be included in future research. Although gender identity has a significant impact on how people experience

and communicate ADHD, these perspectives are frequently missing from studies (Hartung et al., 2025; Kristensen et al., 2023). In addition to providing a more intersectional understanding, broadening the scope of research to encompass a broader range of gender identities will guarantee that support services do not perpetuate binary or cis-normative presumptions (Crenshaw, 1991; Singh et al., 2011).

Research that is practice-based, culturally sensitive, and assesses the efficacy of customised therapies for Asian people with ADHD is desperately needed. This could entail creating psychoeducational resources, school-based curricula, or community-led assistance projects that take into account family dynamics and cultural norms. Research in this field could also examine how culturally grounded approaches affect neurodivergent people's self-efficacy, family communication, and internalised stigma.

The significance of broadening and strengthening our understanding of ADHD through culturally, socially, and structurally informed lenses is demonstrated by these proposed directions for future research taken together. In addition to more appropriately reflecting the lived experiences of neurodivergent young Asian women, future research could influence the larger narratives around neurodiversity, identity, and support by eschewing individualised, Western-centric, and deficit-based frameworks. By influencing more inclusive diagnostic procedures, therapies, and representations – ones that legitimise and centre the varied voices so frequently ignored in the mainstream discourse on mental health – such work can make a significant contribution to both study and practice.

This study has several limitations as mentioned in the methodology chapter even though it provides insightful information about the lived experiences of first-generation Asian women with ADHD in Aotearoa/New Zealand. The findings' applicability to the larger Asian or neurodivergent population is restricted by the small, purposeful sample. The fact that most of the participants identified with a certain Asian ethnic group (Chinese) may not have fully reflect the social, linguistic, and cultural variety seen throughout the Asian diaspora. Additionally, since all of the information was self-reported by participants and derived from retrospective reports, responses could have be skewed by personal interpretation or recall bias. Despite the use of reflexivity, the researcher's positionality might have influenced how the stories were interpreted. These limitations emphasise how crucial it is to use caution when extrapolating the results outside of the immediate sample. To further

validate and enhance these findings, future studies should try to include a wider variety of Asian ethnic groups and use a variety of approaches.

5.5 Conclusion

In the context of Aotearoa/New Zealand culture, this study has followed the personal and frequently unheard-of paths of neurodivergent young Asian women navigating ADHD. Their stories' topics, which range from identity redefinition and the need for representation to cultural silence and family shaming, provide deep insights into how ADHD is perceived and understood outside of prevailing Western frameworks. These findings build on existing literature by emphasising the lived experience as a site of knowledge and resistance and the critical role that the cultural environment plays in influencing diagnostic, familial, and institutional responses. However, this study does have certain limitations. Despite its depth, the sample size was small; thus, it cannot be said to be representative of all Asian experiences with neurodiversity.

Furthermore, although IPA is helpful for deciphering meaning, it is inevitably influenced by the researcher's interpretation. Future studies could expand on this body of research by examining patterns of diagnosis, access, and assistance in greater detail using quantitative methods, incorporating cross-generational perspectives, and considering broader ethnic and gender identities. Fundamentally, this study elevates the perspectives of young Asian women whose experiences have historically been underrepresented in clinical and academic settings. Their experiences encourage us to reconsider our definitions of difference, neurodivergence diagnoses, and identity support in culturally heterogeneous settings.

Appendices

Appendix A

Appendix B

INFORMATION SHEET

Research topic – *Navigating Stigma & Identity: Lived Experiences of Neurodivergent (ADHD) Young Asian Women in Aotearoa/New Zealand*

Kia ora! Hello! 你好! 안녕하세요! Kamusta! नमस्ते! Halo! こんにちは! Сайн уу! ਸਤ ਸ੍ਰੀ ਅਕਾਲ! สวัสดี! Xin chào!

Thank you for expressing your interest in participating in this research.

I would like to speak with Asian women between the ages 18 to 25 who have been diagnosed with ADHD and are first-generation children of immigrant parents. The types of questions you will be asked are predominantly in relation to how receiving a diagnosis of ADHD has impacted your life and identity.

Key terms:

"Lived experience" is the term used to describe an individual's first-hand account of life, which includes their feelings, ideas, and perceptions. Examining lived experience is a useful tool for psychologists and academics who are trying to better understand how people interpret the world, deal with difficulties, and find purpose in their lives.

"Stigma" describes the negative attitudes, beliefs, or stereotypes that society or individuals hold about a person or group based on certain characteristics, behaviours or conditions. Stigma is important in psychology when it comes to understanding how beliefs can impact people's relationships, mental health, and self-esteem.

"Identity" is a term used to describe how people view and define themselves in relation to environmental, social, cultural and personal factors. It includes all aspects of an individual's

identity, including their personality, values, beliefs, and social roles. Identity is a key idea in psychology and its formation is a critical part of adolescence and early adulthood.

What is this research about and why is it important?

This research aims to explore the lived experiences of young Asian women in Aotearoa/New Zealand with ADHD. More specifically, the stigma surrounding mental health disorders in Asian cultures and the identity conflicts that may or may not follow after diagnosis.

This research is important because it is one of the few that concentrates on neurodivergent Asian women. Results of this research will provide guidance for healthcare and support services that are better adapted to different cultural contexts. By exploring lived experiences of neurodivergent, first-generation, young Asian women, we may determine where support mechanisms are lacking and what needs to be improved to support efforts to create environments that are more welcoming and encouraging for everyone.

What will participation look like?

If you decide to participate, I will schedule an interview on Zoom or in-person, depending on your preferences and where you are located. Before the interview, I will invite you to complete a consent form. Please feel free to ask me any questions about the project and/or to consult with people you trust before you decide to participate.

Participation is ***completely voluntary*** – if you do not want to participate, you do not have to. You can also choose to:

- Stop participating at any time before or during the interview/data collection phase
- Withdraw your data up until two weeks after you have received your transcript for review

What are the benefits of participating?

Benefits could include enjoying talking about your experiences. This project may help contribute to the knowledge of mental healthcare professionals and fellow academics wishing to explore this topic further.

You will also receive a $50 koha in the form of a Prezzy card to thank you for your time.

What are the risks of participating and how are they being managed?

Risks to participation are minimal; you are welcome to share as much or as little as you want in response to questions and to not answer questions that make you feel uncomfortable. There

is the potential for you to feel upset or frustrated discussing your experiences if they were challenging for you. Should any distress arise for you, there is also a list of resources at the end of this form.

What will be done with my information?

Interviews will be audio recorded and transcribed. Recordings will be stored on password protected computers in Massey OneDrive. Secure (password protected) means will be used if there is any identifiable data shared between me and my supervisor.

You will be invited to choose a pseudonym (fake name) that will be used to identify you in any outputs from the research. If you do not have a preferred pseudonym, we will select one for you.

All recordings and transcripts will be securely deleted 5 years after the close of the research.

Analysed data may be used in any of the following ways:
- My Master's thesis
- Academic publications
- Academic and/or community presentations
- Policy briefings
- Knowledge translation outputs (e.g. blog posts, infographics, webinars, etc.)

Participant's Rights

You are under no obligation to accept this invitation. You have the right to decline to answer any particular question or to withdraw your data or any part thereof at any time until two weeks after you have received your transcript for review.

Project Contacts

If you have any questions about the research, please contact:

Student Investigator: Irene Zhu

Supervisor: Dr Sharon Crooks, Lecturer, School of Psychology, College of Humanities & Social Sciences, Massey University, Manawatu Campus
Phone + 64 6-951 6082 ext. 83082 Email s.crooks@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application # 4000029385. If you have any concerns about the

conduct of this research, please contact Dr Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800 x 43347, email humanethicsnorth@massey.ac.nz.

Support Resources (All free to contact 24/7 unless otherwise specificized)

A full list of mental health crisis teams is available here:
https://mentalhealth.org.nz/helplines

1737 Need to Talk?
Call: 1737
Text: 1737

Anxiety Helpline
Call: 0800 269 4389

Asian Family Services
Call: 0800 862 342
Email: help@asianfamilyservices.nz
WeChat: AFS_0800862342

Lifeline
Call: 0800 543 354
Text: 4357

Depression Helpline
Call: 0800 111 757
Text: 4202

Healthline
Call: 0800 611 116

Vagus Line (specific to Chinese only)
Call: 0800 567 6666
Email: info@cmh.org.nz
(12:00pm – 2:00pm Monday, Tuesday, Wednesday, Friday)

Appendix C

CONSENT FORM

Research topic – *Navigating Stigma & Identity: Lived Experiences of Neurodivergent (ADHD) Young Asian Women in Aotearoa/New Zealand*

I have read or have had read to me in my first language, and I understand the Information Sheet. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study until two weeks after I receive my transcript for review.

I agree to the interview being sound recorded.
☐ Agree
☐ Disagree

I wish to receive a summary of study findings
☐ Yes
☐ No

I agree to participate in this study under the conditions set out in the Information Sheet.
☐ Yes
☐ No

Declaration by Participant:

I _____ hereby consent to take part in this study.
[print full name]

Signature: _____ Date: _____

Appendix D

School of Psychology
Massey University
Private Bag 102-904
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Auckland 0745
Tel +64 9 414 0800 ext 43116

TE KUNENGA KI PŪREHUROA
MASSEY UNIVERSITY
UNIVERSITY OF NEW ZEALAND

Navigating Stigma & Identity: Lived Experiences of Neurodivergent (ADHD) Young Asian Women in Aotearoa/New Zealand

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have been given the opportunity to review and amend the transcript of the interview conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

Signature: _____ **Date:** _____

Full name (printed): _____

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