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## ***'I felt like a broken person': the experiences of women navigating a late ADHD diagnosis in the UK***

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# 'I felt like a broken person': the experiences of women navigating a late ADHD diagnosis in the UK

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## ABSTRACT

**Aim:** To explore the experiences of women diagnosed with ADHD in adulthood, in the UK.

**Methods:** Eight women, aged between 28 and 53, were interviewed about their experiences of having an ADHD diagnosis in adulthood. Interviews were transcribed verbatim, and the resulting data was analysed using a reflexive thematic analysis. Four themes were developed around women's experiences.

**Findings:** '*A childhood of undiagnosed ADHD*' revealed that participants experienced distress from a young age and reported low self-esteem. The shared narrative of being misunderstood and dismissed by professionals from a young age, with some reporting that the ADHD diagnosis was overshadowed by another diagnosis. '*ADHD as a possibility and seeking out a diagnosis*' captured the series of events that led to participants seeking out a diagnosis, with a running theme of self-advocacy being present. '*Receiving an ADHD diagnosis*' highlights the mixed emotions following diagnosis, the process of re-framing past experiences through the lens of ADHD, and the support offered post-diagnosis. '*Life with an ADHD diagnosis*' highlights the impact that the diagnosis had on participants' sense of self and identity and the interplay between the diagnosis and other identities. Participants' accounts also revealed the impact that stigma had on their experience of ADHD.

**Conclusions:** The findings illuminated the experience of participants navigating mental health, identity and multiple systemic barriers in the context of ADHD diagnosis in adulthood.

## ARTICLE HISTORY

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## KEYWORDS

ADHD; women; adulthood; mental health; diagnosis

## Introduction

Attention Deficit Hyperactivity Disorder, commonly referred to as ADHD, is a neurodevelopmental condition characterised by a group of shared core traits, namely, hyperactivity, impulsivity, and/or inattention (APA, 2013). Interestingly, ADHD was once thought of as a predominantly male condition, highlighted by the common phrase 'naughty boy's syndrome'. While this myth has been debunked,

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statistics suggest that ADHD is diagnosed more often in boys than girls. The most frequently reported statistic is a 3:1 difference, however, the exact statistic has differed based on diagnostic tools and populations (Döpfner et al., 2008). Intriguingly, by adulthood, the male/female gender ratio of ADHD is closer to 1:1 (Biederman et al., 1994; Kessler et al., 2006). This phenomenon has raised two plausible hypotheses (a) ADHD is less common in girls than boys, and (b) ADHD is being underdiagnosed and therefore undertreated in girls.

Research investigating this phenomenon has suggested that the latter may be true, such as women and girls are being underdiagnosed and therefore unsupported with regards to their ADHD (Fedele et al., 2010; Rucklidge, 2010). This hypothesis is consistent with findings which highlight that women are more likely to be diagnosed with ADHD, later in life than men (Hinshaw et al., 2022).

The reason behind these disparities is multifaceted with biological, psychological, and social factors being at play. Biological factors, such as hormones or puberty timing have been suggested to play a role in the observed sex differences, suggesting that neuroendocrine factors (e.g. hormones) impact the expression of ADHD traits (Antonioni et al., 2021). More recently, Eng et al. (2024), proposed a novel theory that suggests that rapid declines in oestrogen (most commonly seen around ovulation) may exacerbate ADHD traits in women. However, research investigating this topic is often conflicting, challenging the ability to draw conclusions from it (Bölte et al., 2023; Martin, 2024).

Social factors such as social norms have also been consistently reported by researchers to contribute to these gender disparities (Hinshaw, 2002; Holthe & Langvik, 2017; Morgan, 2024; Nussbaum, 2012). These findings suggest that women are more likely to 'internalise' their ADHD traits (e.g. tapping their foot, changing positions) to stay in congruence with social norms and expectations (e.g. being 'good' and 'obedient') (Mellström, 2023). Moreover, due to the common association between ADHD and hyperactivity, women presenting with more internalised, inattentive traits tend to get 'missed', leading to them have to cope unsupported (Lynch & Davison, 2024).

These social norms and gender biases do not just impact how women experience ADHD traits but also inform diagnostic criteria, with some studies highlighting the different ways in which women and girls have been systematically marginalised from knowledge production, which has led to our understanding of ADHD being heavily shaped by a diagnostic criterion made by men, for men (Hartung & Widiger, 1998). This point is further emphasised by the fact that until 1979, there was no systematic research conducted on women with ADHD (Kashani et al., 1979).

Psychologically speaking, women who are diagnosed with ADHD in adulthood are more likely to experience depressive symptoms, anxiety disorders, eating disorders, substance use, and low self-esteem (Hinshaw et al., 2006; Rucklidge & Kaplan, 1997; Waite, 2010). While some researchers believe that these co-occurring conditions are independent of ADHD, others believe they develop as a consequence of undiagnosed ADHD (Nadeau & Quinn, 2002; Waite, 2010). Nevertheless, emerging research has indicated that upon seeking out support for distress, women are more likely to be diagnosed with an 'emotional condition', with little effort being placed into investigating the underlying causes (Morgan, 2024). This leads to the ADHD traits being 'missed', decreasing the likelihood of women receiving an ADHD diagnosis (Nadeau & Quinn, 2002).

## ***Impact of diagnosis in adulthood***

The implication of undiagnosed ADHD has been documented to be grave for several decades (Rucklidge & Kaplan, 1997). While numerous quantitative studies have captured the psychological (e.g. increased anxiety) and functional (e.g. organisational, time management, etc.) implications of undiagnosed ADHD, qualitative studies have allowed for a better understanding of these experiences in-depth. For instance, Attoe and Climie (2023) conducted a narrative systematic literature review of qualitative research on adult ADHD diagnosis in the UK. In total, they reviewed eight papers which were analysed using thematic analysis, all of which highlighted the negative impact of a diagnosis in adulthood on social-emotional well-being; with women with undiagnosed ADHD reporting ‘notably low self-esteem’. The authors also reported that without a better explanation, traits were often interpreted as perceived personality flaws, fostering self-blame (Attoe & Climie, 2023; Stenner et al., 2019). This is evidenced by negative automatic thoughts such as ‘You are a failure’ and ‘What is wrong with you?’ (Attoe & Climie, 2023; Lynn, 2019).

However, there has been limited qualitative research documenting the in-depth experiences of individuals who seek an ADHD diagnosis in adulthood, especially based in the UK. As mentioned by Chronis-Tuscano (2022), qualitative methods will illuminate the lived experience of women diagnosed with ADHD, while simultaneously allowing for systematic data collection. Therefore, this study attends to this gap in research by centring the lived experience of women diagnosed with ADHD in adulthood. The clarification and documentation of these voices will facilitate a deeper, nuanced understanding of ADHD in women, the impact of the late diagnosis, and systemic barriers at play.

## ***Study aims***

The purpose this study was to attend to this gap in research and to shine a spotlight on the experiences of women who were diagnosed with ADHD in adulthood, in the UK. Two main questions were proposed in order to address this aim:

1. How do women diagnosed with ADHD in adulthood describe their experiences of being diagnosed in the UK?
2. How has their ADHD diagnosis impacted their identity and daily life functioning?

## ***Position statement***

The first author and lead researcher, SB, identifies with the position of insider (being a woman) outsider (not having an ADHD diagnosis herself). The second author and research supervisor, HK, identifies as insider both in terms of holding a neurodivergent identity (ADHD and Autism) diagnosed in adulthood, and with regards to being assigned female at birth. As such the second author provided ‘insider’ guidance and insight, shaping the planning and conducting of the research.

Both researchers feel strongly that the research should demonstrate a neuro-affirmative attitude (Bradley et al., 2025), reflected in the procedural design and language choices adopted. Despite the dominant ‘deficit-model’ discourse, authors have chosen to use

terms such as ‘co-occurring’ as opposed to ‘co-morbid’, ‘condition’ rather than ‘disorder’ and ‘traits’ (or “symptoms”) rather than ‘symptoms’. However, since the current research focuses on the **experience of receiving an ADHD diagnosis**, person-first language (woman with an ADHD diagnosis) has been retained.

## Methods

Full ethical approval of the study was given in advance by the institution’s Research Ethics committee.

### *Sampling procedure and description of research participants*

Non-probability purposive sampling was used to select participants (Creswell & Clark, 2017; Palinkas et al., 2015). Participants had to be assigned female at birth, and aged 23 or older. Participants younger than 23 would have received this diagnosis via Child and Adolescent Mental Health Services (CAMHS) or education institutions, which would impact the experience of being diagnosed.

The researchers made the decision to only include participants diagnosed in the National Health Service (NHS). This decision was driven by the understanding that participants diagnosed privately or through the right to choose pathway may have had different experiences of being diagnosed (e.g. shorter wait times). Therefore, sampling participants diagnosed from both routes would add unwanted homogeneity whilst simultaneously detracting from the ability to capture and understand the impact that the current state of adult ADHD services in the UK is having on service users.

Participants were recruited using social media, specifically from relevant UK-based Facebook forums, and a total of 26 women made contact. The first eight of these women who met the inclusion criteria of the study participated in an interview, lasting between an hour to an hour and fifteen minutes. As it was not possible to include all the remaining women due to time constraints on the study, the rest were thanked for their time in volunteering to participate and it was explained that recruitment was now closed. These women were directed to relevant support organisations, if required.

The eight participants were adult women, aged between 28–53 (average age was 41 years). All participants lived in the UK, with six participants identifying as White British (one Scottish and the rest English), and two participants identifying as Asian or Asian British (South Asian). On average, participants had been diagnosed two years and six months prior to the interview date. All participants had been prescribed medication as a form of symptom management. Demographic information has been summarised in [Table 1](#).

When it comes to decisions regarding sample size, Braun and Clarke (2019) argue that data saturation is not a useful concept within RTA, since there is a tension with the fundamental value of this methodology. However, given that this study had a practical need to determine a sample size due to the time-constraints, a provisional sample size of eight participants, with the anticipated lower range being six participants and the upper range being ten participants was decided. This estimate, assuming the quality and richness of data collected (Braun & Clarke, 2019) was based on similar research in the field that has investigated this phenomenon (Holthe & Langvik, 2017).

**Table 1.** Participant demographic information.

| Name   | Age Bracket | Ethnicity                            | Years since diagnosis | Prescribed medication as a form of symptoms management? |
|--------|-------------|--------------------------------------|-----------------------|---|
| Ava    | 40–45 years | White British                        | 2 years and 2 months  | Yes   |
| Daphne | 35–40 years | White British                        | 5 years               | Yes   |
| Lauren | 50–55 years | White British                        | 8 years               | Yes   |
| Sophia | 40–45 years | White British                        | 6 months              | Yes   |
| Ayesha | 40–45 years | Asian or Asian British – South Asian | 8 years and 6 months  | Yes   |
| Zara   | 35–40 years | Asian or Asian British – South Asian | 11 months             | Yes   |
| Ella   | 40–45 years | White British                        | 1 year and 10 months  | Yes   |
| Emma   | 25–30 years | White British                        | 1 year                | Yes   |

Note. \*All names are pseudonyms.

### Procedure

Offered the choice between online or face-to-face interviews for maximum accessibility, all participants expressed a preference to participate online due to other commitments such as looking after children or working. All interviews took place between April 2023 and September 2023.

Data was collected using semi-structured interviews on a one-to-one basis (Braun & Clarke, 2022). An interview schedule (see Table 2) was developed which was informed by existing literature exploring the impact of ADHD diagnosis in adulthood, in women. Prompting questions were used when participants went off track or to encourage participants to elaborate more on certain topics.

Following completion of the interview, all participants were debriefed, and a check-in was conducted on their wellbeing. Most participants reflected on finding the interview experience interesting and felt as though it gave them the space to reflect on their journey. While no participants reported distress from the interview process, the support organisations detailed in the debrief were highlighted regardless. No participant withdrew from the interviews nor later requested the removal of their data. No compensation was provided for participation.

### Data analysis

Interviews were recorded and transcribed verbatim. Following this, a reflexive thematic analysis (RTA) was used to analyse the data generated (Braun & Clarke, 2022). A critical realist approach was taken (Bhaskar, 1975, 1979), which assumes an objective and

**Table 2.** Interview schedule.

1. Can you tell me about your experience of being diagnosed with ADHD?
2. What drove you to seek an ADHD diagnosis?
3. How did the ADHD diagnosed in adulthood impact how you view yourself/your identity?
4. How did the ADHD diagnosis impact your daily life functioning?
5. In your opinion, what needs to be changed or improved on?

independent reality, but that meaning is constructed through subjective experience. This study adopted epistemological pluralism incorporating both a social constructionist lens and an experiential lens. Here, the authors recognise that there are multiple discourses around the ways ADHD is socially constructed (Qui et al., 2011; Moncrieff et al., 2015). These different discourses undoubtedly mediate the participants' meaning making and thereby colour the lived experience of the phenomenon. The lived experience of the phenomenon is intimately tied to the participants' identity or sense of self. For instance, an individual who views ADHD as a medical disorder may believe 'I have a disorder' versus 'I am different to others', thereby shaping their subjective experiences of ADHD. This aligns more with an experiential approach to gaining knowledge (Willig & Rogers, 2008). Neither of these perspectives in isolation aligns with our view on how we gain knowledge. Instead, the authors recognise that both assumptions give us partial access to knowledge of the phenomenon.

The six-stage process suggested by Braun and Clarke (2022) was followed in an iterative manner with movement between stages and was undertaken by the primary author. The 15-point checklist for good RTA developed by Braun and Clarke (2022) was also referred to regularly enabling the monitoring of quality and rigour during the analysis. For instance, coding of non-linguistic features, a thorough, inclusive, iterative thematic process, regular reflexivity, and transparency were some of the ways in which this study promoted trustworthiness, rigour, and qualitative quality.

#### **Phase 1: Familiarisation with The Data Set.**

This phase included three key stages and began with familiarisation with the data set, involving repeatedly listening back to the interview recordings, transcribing them, and checking them for accuracy. During this part of the process, the lead researcher often closed her eyes trying to paint a picture of what the participant was saying. She also asked herself questions such as: 'How did my participant make sense of what they are discussing? What was it like for them?'. Alongside this, she took preliminary notes, writing down any initial ideas, feelings or thoughts that were arising.

#### **Phase 2: Coding.**

Coding was often an evolving process and began with a line-by-line reading of the transcript, stopping every time something relevant to the research questions was spotted. If something felt relevant, the lead researcher developed an analytically meaningful description, or 'code'. If a code already existed, she added it to the pre-existing code and reflected on whether its name needed to be tweaked. The coding was refined multiple times until the lead researcher was satisfied with the amount and depth of the codes.

Following this first round of coding, the transcripts and initial analysis were shared and discussed with the research supervisor (second author). At this point it became clear that more attention had been given to the social constructivist layer, at times ignoring the experiential layer. Through supervision, the lead researcher was encouraged to dig more deeply into the latent aspect of the experiential layer, interrogating what the participant's language or non-linguistic features, such as repetition or pauses might reveal about the quality of their experience. Re-doing the coding at this stage enabled the development of a more balanced set of codes, speaking to both epistemological dimensions.

#### **Phase 3: Generating Initial Themes.**

The analysis then shifted from codes to themes, where the aim was to develop a shared pattern of meaning organised around a central concept across the dataset. Codes that

shared a core idea or concept that were relevant to the research question were clustered together giving rise to candidate themes. As expected, this yielded a large number of themes, which brought the analysis to the next stage.

#### **Phase 4: Developing and Reviewing Themes.**

This phase aimed to continue assessing if the candidate themes fit the data. Here, it was helpful to develop a theme map to visually represent how the data was sitting together. Themes that did not fit with the data set or were not addressing the research question were discarded. This was often a recursive process whereby the lead researcher went back and forth and attempting not to get too attached to the story she was developing.

#### **Phase 5: Refining, Defining, and Naming Themes.**

After having a set of themes and codes that told a story, the lead researcher began fine-tuning the analysis. Following the guidance of Braun and Clarke (2022) she wrote a theme definition for each of the themes generated which was essentially an abstract or description of each theme. These themes were then explored in supervision with the second researcher, with whose guidance the names of the themes were revised.

#### **Phase 6: Writing Up.**

This phase calls on the researcher to build an analytical narrative that tells a coherent and persuasive story to the reader. Therefore, following her initial write-up and discussions with second author, the lead researcher revisited Phase 4 and Phase 5, which facilitated the development of a more robust and coherent story.

## **Findings**

Four themes were identified across the eight interviews and are presented below with verbatim quotes (see [Figure 1](#) for theme map). All names and identifiable information have been amended to protect the anonymity of the participants; instead, pseudonyms are used.

### ***Theme 1: growing up with ADHD undiagnosed***

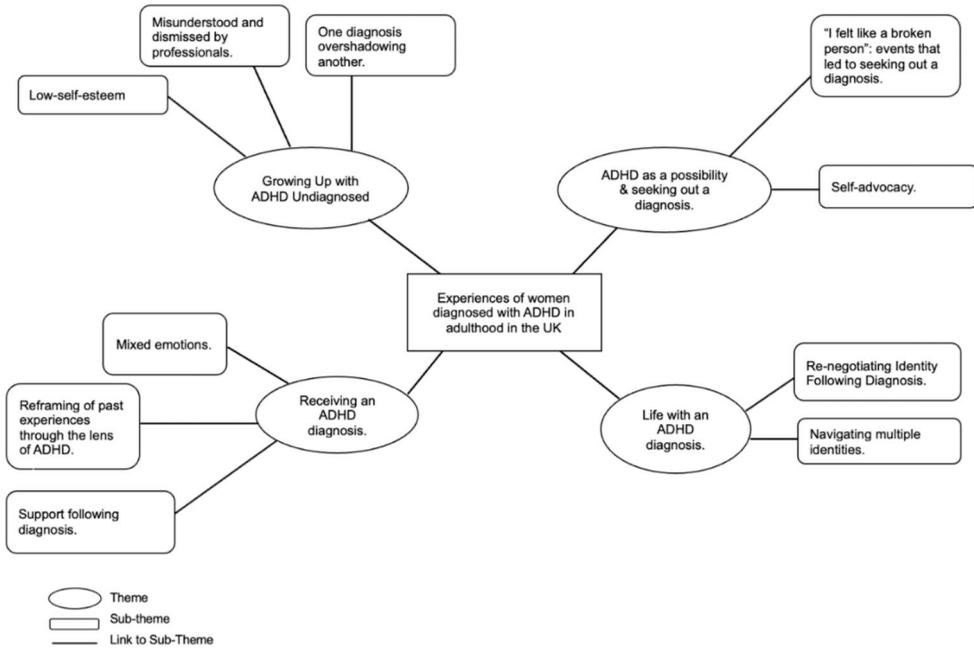
In this theme, participants reflected on the impact that undiagnosed ADHD had on their early life.

#### ***Sub-theme: low self-esteem***

When exploring their childhood, all eight participants reported feeling ‘different’ than the people around them. This feeling was often encountered at a very young age. Without a framework to understand themselves, participants often associated their perceived difference as being representative of personality flaws, which consequently hindered their sense of self and their self-worth.

I’ve always known, like throughout my childhood that there was something [brief pause] something not right. (Zara, p. 2, L38-39)

I’ve always had this back thought of there’s something different with you, and there’s something wrong with you, but what is it? (Emma, p. 26, L437-438)



**Figure 1.** Thematic map of main themes and sub-themes with legend.

This feeling was reinforced by friends and family who often ascribed negative labels to participants such as being a ‘lazy’ and ‘quirky’. Some participants also recalled being bullied at school for their differences, from both peers and teachers.

It was very much, well, you can do maths, so there’s nothing wrong with you. You’re just lazy. They’d [the teachers] would tear my work up in front of me in class and they’d use it as an example of what not to do and I-I-I got really quite bullied by the teachers. (Sophia, p. 3, L70-72)

To protect themselves from the bullying, participants would resort to removing themselves from social situations.

I preferred to just, you know, take myself away because I knew I was, you know, odd and different. And in order to stop me being picked on or getting into trouble I would just take myself away. (Ella, p. 5, L105-107)

The repeated nature of this negative feedback also impacted participants’ sense of self and caused significant distress.

I would always beat myself up in the past about um, oh, I can’t, you know, like procrastinating and stuff like that, and I’d be like ‘just get on with it’, ‘just do it’, ‘just do it’. And I couldn’t. My brain would stop me, and I would beat myself up about it. (Daphne, p. 8., L163-165)

Daphne’s extract sheds some light on the conflict that she experienced internally when she needed to complete a task. On one hand, she had a drive to ‘get on with it’, whilst on the other than she faced the reality where she ‘couldn’t’ because her ‘brain would stop her’. Here, the repeated use of the metaphor ‘beat myself up about it’ highlights

the blame and shame she experienced for not being able to complete the tasks. This phrase also implies a sense of harshness or aggressiveness in the way Daphne would speak to herself in these moments. A similar experience is echoed by Ava who felt like her ADHD traits were representative of a personal failing leading to the development of beliefs such as ‘I such am a failure’.

### ***Sub-theme: misunderstood and dismissed by professionals***

Participants reported experiencing distress, which began at a young age, and was experienced not just psychologically, but also psycho-somatically. All participants reported at least one event of seeking out professional support for the distress they were experiencing. For many of them, this began by their parents reaching out to their GPs with the aim of getting more answers.

I was first seen by kind of somebody for mental health or worry when I was seven, and I’ve still got the letter, and it’s so interesting now because it’s basically ADHD. I was getting a lot of tension headaches, which I know is from really trying to do better in the classroom but not being able to take in information. (Emma, p. 11, L175-178)

However, upon seeking out support, participants were often misunderstood or dismissed. No meaningful attempt was made to understand the basis of the difficulties they experienced, leaving participants feeling a profound sense of disappointment and anger for the lack of understanding provided by professionals.

So, I went to the doctor and she literally – I’ve still got the letter – she wrote ‘Emma will likely suffer with psychosomatic symptoms for the rest of her life’ [...] Yeah so, they recognised that it was my neurology like but nothing else was kind of looked into. (Emma, p. 11, L183-189)

### ***Sub-theme: one diagnosis overshadowing another***

After experiencing persistent and enduring mental health distress, most women were given a diagnosis by GPs, clinicians, or professionals. As spoken by Emma, and echoed by other participants, her ‘struggles have always been framed as mental health’ (p. 16, L253-254). As a consequence of doctors framing their distress through the lens of mental health, participants were often prescribed Cognitive Behavioural Therapy (CBT) as a means of addressing their ‘symptoms’. Participants recalled having mixed experiences with CBT, with some finding that it helped with self-awareness and with others highlighting that it was hard to engage in CBT due to the focus on homework. This led to their so-called ‘symptoms’ being regarded to as ‘treatment resistant’, which is a term used to describe clinical cases where an individual does not respond to ‘first-line’ treatments.

I could do CBT till I’m blue in the face. I know why I behave in certain ways. I like to think I know my emotions well, but I’m still figuring that out, but like, I can name them, if that makes sense? But there is still something missed, and I do not know what it is. (Emma, p. 28, L476-478)

Some participants also experienced being moved around multiple diagnosis (e.g. borderline personality disorder, bipolar disorder). Practitioners rarely asked participants their

perspectives on the diagnoses being ascribed to them, stirring feelings of anger. Over-time, these diagnoses also overshadowed the underlying ADHD.

Now, I've been diagnosed with ADHD and-and Autism, and they make far more sense than the diagnoses I had in the past. I very bitter about it. I can't deny it. I am so angry. (Daphne, p. 14, L330-331)

In one participant's case, rather than a mental health condition, it was a neurodevelopmental condition, dyslexia, that overshadowed her ADHD.

Dyslexia was kind of because of school, and my spelling, and my reading, and my writing erm, and getting frustrated in class. (Sophie, p. 3, L54-55)

As Sophie grew older, she recalled that ADHD 'was never really put up'. Instead, 'it was put down as depression or social anxiety'. Moreover, the things that she had put in place to manage her dyslexia were no longer working. This led to Sophie feeling frustrated as 'all the things were the same things that I've been saying for years', illuminating that she had not been heard or listened to 'for years'.

### ***Theme 2: ADHD as a possibility & seeking out a diagnosis***

This theme captures the journey that occurs after women learn and query the possibility of their 'symptoms' being manifestations of ADHD, and the subsequent process of seeking out a diagnosis.

#### **'I felt like a broken person': Events That Led To A Diagnosis.**

Of the eight participants, six learned about the gender specific presentation of ADHD through articles written by other women who had been diagnosed with ADHD in adulthood or by researching this topic further. However, upon first learning about this, most participants dismissed this as being relevant to them.

It wasn't something that I thought of for me, but the more I read into it, it made a lot of sense. (Sophia, p. 2., L33-34)

For some, this was due to a dissonance between their lived experience of ADHD and the media's portrayal of ADHD.

More recently it's ADHD in adults has been I suppose more talked about, but in 2011 [...] it was naughty boys in classrooms. So, I thought, you know, I'm a grown woman, I've got three children, I don't have ADHD. [...] I wasn't insulted but I just thought, you know, I don't have that. I am not naughty. And it wasn't until 2018 that I looked into it and actual adult, rather than the stereotypical naughty boy and I thought oh, I didn't even know these symptoms existed especially in women. (Daphne, p. 4, L.73-79)

However, as time passed, participants often found themselves going back to the articles and reflecting on feeling seen and understood in a way that they had perhaps never experienced before.

I started reading it and the the tears just started falling, like they just fell [...] because I was like oh my God, that's me. That is – that is me. How was I so unaware? (Ella, p. 11, 233-238)

Unlike in the experiences above, Ayesha and Daphne's diagnosis was first queried as a possibility by professionals. For instance, Ayesha had experienced a series of difficult events, following the ending of her marriage and her return to university as a mature

student, where her ‘inability to grasp one assignment within a philosophy module’ was ‘catastrophised to me failing the module, failing the course, being kicked out of university, not being able to provide for my children, and my children being taken away from me’. Ayesha also adds that her background of being a South Asian British woman, further exacerbated these experiences:

There was so much linked to me going back to studies [brief pause] culturally, within the family, for myself. (Ayesha, p. 3, L67-68)

Faced with these distressing thoughts, Ayesha felt as though she ‘couldn’t cope with this’, resulting in her attempting to end her life. Reflecting on this time, Ayesha says:

I obviously believe it was a cry for help. I don’t believe I genuinely wanted to die. (Ayesha, p4, L80-81)

Following this, she was taken to a psychiatric outpatient unit where a mental health social worker queried ADHD, referring her for an assessment.

In Daphne’s experience, the possibility of ADHD arose when she was eight months pregnant by her psychiatrist with whom she had regular appointments due to her co-occurring diagnoses.

It never occurred to me when it was first mentioned in 2011. I straight away said, ‘oh no, I don’t have that. Like not even a possibility. (Daphne, p. 3, L. 47- 48)

### ***Sub-theme: self-advocacy***

Following ADHD becoming a possibility, women would then begin the process of seeking out a diagnosis. A commonality between the experiences of some women was the process of advocating for oneself in order to receive access to an assessment. Participants were often hesitant and held off from pursuing an assessment due to fears of being dismissed and rejected by professionals. On this note, most participants recognised that their current experiences of help seeking were shaped by past experiences.

I needed to have enough evidence to go to the doctor with, you know, that was the thing, like how can I prove this? Like how can I go in there [...] to get my best outcome because, you know, a lot of us are used to battling medical professionals and kind of asking for respect and to be asked, you know, spoken to, and to have our problems taken seriously. (Ava, p. 13, L259-264)

Participants found themselves going into the appointment with their GP armed with additional information in order to get access to an assessment, some had to re-engage in the familiar battle with professionals.

Then I rang my GP, and it was a bit of a process, to be honest, and I was trying to convince my GP to put me through with the assessment. (Zara, p. 2, L31-32)

However, after going their GPs some participants were told that they should expect to hear back in ‘years and not months’. As most participants were in significant distress at this time, they had to advocate for themselves in order to be seen promptly.

It felt like forever, but to be honest, I didn’t have to wait as long as so many others, and I’m very fortunate for that but I’m also very good at advocating for myself sometimes.

Sometimes, not all the time. But it was also important enough for me to get this diagnosis could that I could move on with my life. (Ella, p. 15, L325-328).

### ***Theme 3. Receiving an ADHD diagnosis***

This theme relates to the experience of participants receiving an ADHD diagnosis.

#### ***Sub-theme: mixed emotions***

Upon being given the diagnosis, participants recalled experiencing a range of emotions. On one hand, the clarity provided by the diagnosis made participants feel ‘validation’ and ‘relief’.

Validating because it was like I’d suspected by the time I got a seat; I’d been suspecting it for a few years and it was like, yeah, this is who you are. This is what you need. This is you know – and it was somebody telling me that you will find it difficult and there’s a reason for it. (Ava, p. 7, L. 118-120).

However, alongside these emotions, participants also felt emotions such as anger. This was one of the occurrences where participants were allowed to be angry, not just at themselves, but also at others.

I think I remember for the first say 2 weeks or so, I didn’t tell anybody because I just felt really, really angry, like the angriest I’ve ever felt, and I just felt frustrated and [...] it was almost like I had processed it being a relief in the waiting period so then at that point you know the different stages of grief? I was literally grieving for my little Emma [gets teary]. (Emma, p. 7, L111-115)

#### ***Sub-theme: reframing of past experiences through the lens of ADHD***

Equipped with the knowledge and awareness provided by the diagnosis, these participants had a framework to understand themselves. This understanding fostered feelings of acceptance as participants could recognise that the label ascribed to them at an early age was not representative of personality flaws or something being innately ‘wrong’ with them, but instead the manifestation of their ADHD traits. This is also evidenced by a shift in language from questioning ‘wrongness’ to talking about ‘difference’.

I’d done really well at school in my GCSE’s and then when it got to A-levels, my life just fell apart, and it all went horribly wrong from then and people said ‘I didn’t put enough effort in’ and I felt bad about myself, and then when I got the diagnosis, [...] it wasn’t like an excuse, but it was a reason that these things might have happened, and from that um [...] it wasn’t that I was a failure in everything, it was just that I hadn’t properly received treatment for um neurodiversity, I suppose. (Daphne, p. 6, L.120-125)

It [the ADHD diagnosis] kind of helped because [...] it shows that I’m not lazy [...]. Knowing I’ve got ADHD kind of helps realise and pace myself and not beat myself up too much. (Lauren, p. 29, L628-633)

This framework to understand themselves also facilitated the development of self-compassion.

I would never be nice to myself because I always thought I was a failure. You know that I was a broken person, and I’m not at all. I’m just a very, very typical inattentive ADHD women,

and there are thousands like me. [...] I'm not broken, not like wrong, just different. (Ava, p. 31, L645-656)

The movement from a narrative filled with judgement and shame, to one encompassing understanding and compassion also allowed women to find new ways of managing their distress.

Once I got diagnosed, there became less negative talk because, you know, I could say, okay or that I had more resources and techniques that I could put in place to help complete tasks. (Daphne, p. 8, L165-167)

Alongside compassion for themselves, participants also reported that receiving the diagnosis facilitated feelings of compassion towards others, including caregivers.

I've got more acceptance of-of everything and when I say everything, I mean, I accept the fact that, you know, my parents couldn't meet my needs because they weren't equipped themselves knowing what I know now [...] I've been able to cut them some slack. I've been able to cut myself some slack. (Ella, p27, L.610-614)

### ***Sub-theme: support following diagnosis***

One of the many motivating factors for women to seek out the diagnosis was access to support and help. However, upon receiving the diagnosis, most women reflected on their experience of being offered medication as the only form of support and management.

But in the actual moment of being diagnosed, I was like angry, and then it was yeah, yeah, do you want a medication appointment or not? I'll send you a report and see you later. (Emma, p. 9, L136-138)

Of the eight participants, one participant was offered psycho-social support in the form of a group, which was reported as being helpful as it fostered a sense of connection.

It was a group. It was, as I say, organised by the ADHD clinic in I think it's under [borough she lives in] borough [...] it was run by I think it was a nurse who also had ADHD and [...] she'd do like a presentation, some slides and she shared some experiences that were hypothetical or whatever and then she'd ask us if we could relate, if we tried anything erm could we give an example of something that had gone like that? And then she'd give us some tips on maybe how to deal with it. [...] It was only four sessions, and it was for an hour, and it was literally every week for four weeks. (Sophia, p. 7, L175-182)

Well, it was nice to know that other people were struggling. (Sophia, p. 8, L187-188)

The lack of support offered post-diagnosis was reflected on by a few participants, with some noticing that had they been diagnosed at a younger age, more support may have been available.

On one hand it's like [...] woo, I've solved the problem. You know, like eureka, I know what it is, you know the problem I've been trying to figure out for 40 years, I figured it out, but then it's – you are kind of left with that, I guess emptiness because there is no support when you turn – when you're in adulthood. (Ella, p. 21, L477-480)

There needs to be more support groups out there, support groups for adults definitely, because there's hardly anything around. (Lauren, p. 34, L777-778)

The focus placed on medication was also concerning given that not all participants had had positive experiences of pharmacological intervention in the past. Some did not want to take medication due to the side effects and/or negative past experiences.

My impression and understanding of the medications that were available at the time was that a lot of them did come with the side effects of anxiety, depression, and suicidal thoughts and I was already in that, and I was like I can't really – can't really risk it. I mean I tried one antidepressant, and it zonked me out so much that I couldn't even drive my children to school. So, there are so many layers to consider and so I decided – I took the choice not to. (Ayesha, p. 7, L163-167)

Moreover, participants who were given access to further support reported that most of these initiatives were started by individuals who had lived experience of being diagnosed with ADHD and started groups by 'taking it upon themselves' without access to funding. Instead, they have attempted to find money 'within the existing budget to create a new service. Therefore, support that goes beyond medication appears to be very much a post-code lottery, which may be due to the limited resources available to many services. This often left participants needing to access traditional mainstream support, which may not be catered to their diagnosis.

So, when I went for my erm – when I went for my confidence and low self-esteem therapy, it was group sessions, but I went here [brief pause], bright yellow walls and the lights are on, and I straight away, I was like – and I felt bad because obviously [...] on one else there had ADHD, they all had different things. So, I was like, I said, you know, I felt really bad, I was like, 'can you turn the lights down?' (Lauren, p33, L738-742)

Participants also shared turning to social media groups as a way of building connection with other women who are also going through the same thing. This was often reported as a positive experience.

Being diagnosed right now and having that label is quiet empowering for me because I do [brief pause] I've recently, in the last year or so, done things like join Facebook groups, um, Instagram, followed particular people [...] and it's been really nice to see that I'm not the only crazy one out there [laughs]. (Ayesha, p. 8, L194-198)

However, in one participant's experience, connecting with others was more of a mixed experience.

I feel quite guilty about this thought but I-I think it's a really core experience for a lot of people. It's the flip side of feeling like you're special and that you're different and you're unknowable, and you know nobody can understand you [...], and then you find thousands of people who are exactly like you, and you're probably never had a unique experience in your life [laughs]. (Ava)

#### ***Theme 4 – life with an ADHD diagnosis***

This theme captures the experiences of women reflecting on their lives post-diagnosis.

##### ***Sub-theme: re-negotiating identity following ADHD diagnosis***

A shared experience between participants was that of re-negotiating their identity and their relationship with themselves, post-diagnosis. This was often illuminated by participants pondering over questions such as, 'Who am I?'

It's really quiet conflicting actually, because at the same time you look over your behaviours and actions and throughout your life and situations and circumstances, and you think – how much of that is ADHD and how much of that is me? When you're diagnosed quite later in life, it's really difficult to-to-to categorically go 'well that's because I've got ADHD', because I've-I've lived 30 plus years of my life. (Ayesha, p. 10, L247-251)

To be honest it has completely, completely changed the whole kind of guess identity. (Emma, p35, L579-580)

These questions did not have straightforward answers, with this process being regarded as an ongoing journey.

I think I'm – I think I will still be figuring out who I am for a while. (Emma, p38, L642)

It's every day. It's still – it's still discovery, you know, like every day is a school day. (Ella, p25, L568)

### ***Sub-theme: navigating multiple identities***

Alongside re-negotiating their relationship with themselves, participants also spoke about their experiences of navigating their multiple identities in the context of the ADHD diagnosis. In the following sub-theme, the interaction between having ADHD and being a woman is explored in the context of being a mother, being a female, and holding a cultural identity.

Of the eight participants recruited, six participants reflected on the interplay between their ADHD diagnosis, being a woman, and their experience of motherhood. For some participants, ADHD traits compounded the pressures of motherhood, therefore impacting their experience of mothering. However, prior to the diagnosis, they did not have a framework to understand their experiences, leading to distress.

I mean my time keeping is awful. It's awful. [...] Before, the school was about ten minutes away and I'm not even joking, every single day, I was late, and it got to the point where one day, I said no [brief pause] and this was before my diagnosis I'm going to wake up at six in the morning [brief pause] there's no way that I can be late, and I'm still late. Can you believe it? [...] So, it's just really frustrating. (Zara, p8, L167-172)

However, most participant shared that they felt that gaining the diagnosis made them a better parent as it gave them a language to communicate their differences with their children.

But I try to keep an open dialogue with my children about it, because I don't want them to assume things. I'd rather they be more aware of the factual basis of it and how it actually – there's nothing wrong with mummy, my brain is just wired differently. (Ayesha, p.17, L407-410)

However, for some, while their diagnosis led to increased awareness and compassion for their children, this also came with its unique challenges.

So, it's difficult, you know, being a parent um when you can pick up the sort of things that your child is doing. So, I suppose if anything, it has given me a lot of awareness um which can sometimes be like [...] I want to switch it off and just be really um aloof to what's going on around me. But you can't. (Zara, p. 12, L303-306)

Participants also reflected on the interplay between ADHD, being a female, and the impact of hormonal influences and menopause, on their experience of ADHD. Two

participants spoke about worsening of more challenging ADHD traits, following the onset of perimenopause/menopause, such as difficulty in sustaining attention, organisational difficulties, and increase fidgeting.

Especially now, in the menopause bit, because everything is exacerbated. As I said, even more so. I feel even more bonkers now. I'm more clumsy. (Ayesha, p8, L198-199)

Yeah, especially because I'm going through puberty again, the hormones are going wild [laughs]. (Ella, p. 22, L.494)

Interestingly, both women reflected on being able to see a connection between hormonal changes and worsening of certain ADHD traits, at different stages of their life and/or with hormonal birth control.

Right, so when I look back at some of the, I joke, the stunts I pulled or some of the scraps I got myself into, I see a massive connection to when I started my period and the connection to it subsequently when I had my – when I look back as well – everything was exacerbated when I had children [...], following having them I struggled heavily with my mental health, and I do believe now that, that would have been exasperated by ADHD. (Ayesha, p. 18, L434-437)

Of the eight participants, two participants reflected on how their identity of being a woman and their cultural identity have shaped their experience of ADHD.

I have to also include I'm a first generation born here so I had very traditional Muslim, Asian parents and I grew up in a very white, middle-class area and I just wanted to access and do things that normal teenagers in my area did and back then it was very difficult for me. So, I understand now that I was already masking from a young age [brief pause], elements that didn't have anything to do with ADHD, if that makes sense? (Ayesha, p. 5, L122-126)

In Zara's experience, the stigma of ADHD in South Asian communities has led to her facing increased stigma and shame, with some family members questioning the validity of her diagnosis.

I do think there's still a lot of ignorance and quiet a lot of almost stigma and embarrassment attached to it and for example, you know, most members of my family, if I say I've got ADHD, they'll look the other way and start talking about something else. (Zara, p. 15, L331-333)

My mum still, you know, very much, it's not [ADHD], you know – you're just lazy and you've always been lazy. (Zara, p. 15, L340-341)

### ***Sub-theme: impact of stigma on the experience of ADHD***

In some experiences, the rise in awareness of ADHD has negatively impacted the lived experience of ADHD, leading to increased stigma.

The imposter syndrome kicks in like do you really have ADHD or is this an excuse to the point where I'm doubting myself and thinking maybe I don't have ADHD [...] I suppose there is a bit of stigma attached to it because everyone I mentioned it to was like [clicks tongue], I wish I had ADHD because I've got DSL like um like a plan for basically for – so I get like a laptop to do my exams for example. 'Oh, I wish I had ADHD so I could have a laptop', and I'm thinking, you have no idea. (Zara, p12, L261-276)

For others, the invisible nature of ADHD fostered discrimination. This was heightened during the COVID-19 pandemic where Lauren was refused an appointment to get her eyes tested as she could not wear a mask, although she was exempt from wearing one. This led her to have a panic attack, highlighting the profound distress she experienced as a result.

Because I wasn't in a wheelchair or because I didn't only have one arm, or because I didn't have two heads, or because I didn't have scars showing, I was penalised [...] I was discriminated against. (Lauren, p. 23, L518-520)

Therefore, the analysis of the participant interviews led to the identification of four main themes: (1) A childhood of undiagnosed ADHD; (2) ADHD As a Possibility & Seeking Out a Diagnosis; (3) Receiving and ADHD diagnosis; and (4) Life with an ADHD diagnosis. These findings collectively tell a story of participants' journeys navigating an ADHD diagnosis in adulthood, the UK. This central story highlights the experience of navigating mental health, identity and systemic barriers in the context of a diagnosis of ADHD in adulthood.

## Discussion

This qualitative study adds to the limited previous research on women's lived experiences of an ADHD diagnosis in adulthood, in the UK. Understanding this lived experience is key as it highlights areas that need change, with the long-term goal of improving the outcomes of women and girls with ADHD.

The findings of this study shed some light on the impact of growing up with undiagnosed ADHD, with distress and low self-esteem being common experiences, consistent with previous research. Furthermore, it also highlights two significant experiences at play that hindered participants' ability to be diagnosed promptly – firstly, being dismissed and misunderstood by professionals and the phenomenon of one diagnosis overshadowing the underlying ADHD diagnosis. This aligns and adds to previous research that has found that women's distress is more likely to be phrased through the lens of mental health, than neurodiversity (Morgan, 2024). This also had significant implications for treatment options available, adding to William et al.'s (2024) study which reported that non-adapted generic CBT may be unhelpful and harmful for individuals with ADHD.

The journey to seeking out and receiving a diagnosis was not straightforward, however, this stage has received little attention in research. For instance, in spite of making the connect between their 'symptoms' and ADHD, participants held off from approaching their GP to query a diagnosis, citing that this act required 'courage'. When exploring this further, it appeared that participants believed that approaching their GP would lead to them re-engaging in a familiar 'battle' with professionals, with fears around losing this battle and being dismissed once again, being eminent. As a result, participants waited to seek out help and support until their mental health further declined and they were in significant distress. Their accounts also reflected that they had to advocate for themselves throughout the process of gaining a diagnosis. This need for advocacy may be yet another consequence of the epistemic injustice that excluded women from knowledge production of ADHD, thereby further marginalising this population (Craddock, 2024).

The emotional and psychological impact of the diagnosis was mixed, with participants feeling as though the diagnosis had validated their feelings of difference and the lifelong quest for finding an explanation for their difficulties had come to an end. Feelings of anger, sadness and grief were also common experiences with participants expressing a sense of anger for the multiple systemic failures that hindered their chances of getting a timely ADHD diagnosis, and the distress they endured as a result. This aligns with the findings of previous research (Holthe & Langvik, 2017; Morgan, 2024; Young et al., 2008).

The diagnosis also provided participants with a framework to understand and re-frame their experiences. Armed with this knowledge, participants were able to relocate some of the blame they had internalised for their previous difficulties and failures, alleviating some of the distress they were experiencing. These findings align with the body of evidence that has highlighted that women with undiagnosed ADHD are more likely to have an external locus of control, resulting in feelings of powerlessness, self-blame, and anger (Attoe & Climie, 2023; Lynn, 2019). The present study extends these findings by adding that the diagnosis facilitated the movement towards a more balanced locus of control, empowering women as a result. Contentiously, some researchers have suggested that an ADHD diagnosis diminishes self-control and therefore responsibility due to increased focus on deficits (Koi, 2021). However, the accounts shared by participants in this study suggested a contrary finding whereby the diagnosis empowered women to take back control and responsibility.

In terms of support following diagnosis, experiences were varied, with some participants being offered access to a support group, while others were only offered medication. The lack of psychological support offered was also concerning as participants in this study reflected on having mixed experiences with ADHD medications, with some finding this more helpful than others. Taken together, these experiences indicate that some individuals are being left with little-to-no support following their diagnosis.

The diagnosis also impacted participants' sense of self, leading to them re-negotiating their identity. Alongside their relationship with themselves, participants also spoke about how they navigated their multiple identities in the context of the ADHD diagnosis. Firstly, participants who had children recognised the additional challenges they faced during motherhood due to their ADHD. Moreover, participants in this study reported worsening of ADHD traits during menopause, sharing that they had limited evidence-based research to turn to as a way of better understanding this interaction. The participants of this study also noticed that they experienced a worsening of traits during periods of hormonal changes such as following childbirth and the onset of menstruation. These experiences are supported by research that has highlighted that women with ADHD are at a higher risk of hormone-related mood disorders, specifically premenstrual dysphoric disorder (PMDD) and postpartum depression symptoms (PPD) (Dorani et al., 2021). Whilst, emerging research has suggested a link between ADHD traits and the menstrual cycle, further investigation is needed to clarify and understand this link, specifically during periods of hormonal fluctuations such as puberty, menopause, and childbirth (Eng et al., 2024).

Women in this study suggested that the intersection between ADHD, gender, and ethnicity led to increased stigmatisation, which was a byproduct of multiple factors. First and foremost, participants reflected on ethnicity-specific stigmas whereby ADHD was

portrayed as a moral failing, with some family members and members of the wider community sharing sentiments such as ‘I will pray for you’ upon participants disclosing their diagnosis. Whilst literature in this area is limited, Moody (2016) highlights a number of intersecting factors at play, including social stigma, and mistrust of education and health care systems. Within the UK, Sotire (2025) similarly raises concerns around stigma with regards to neurodiversity within the Black community, hindering access to support in mainstream education systems.

Secondly, the conflict between gender norms and ADHD traits was amplified in the light of cultural norms of being a woman. These norms often overemphasise gender roles such as caretaking and narratives such as the ‘strong Black woman’ who expected to work ‘twice as hard for half as much’ (Agyei, 2022; Brissett-Bailey & Choudhury, 2023). Understanding these findings in the context of this intersectionality framework highlights the way participants consequently battle multiple systems of oppression (e.g. sexism, ableism, and systematic racism). This intersectional stigma shaped therefore participant’s lived experience of ADHD.

### **Limitations**

Of the eight participants, the majority (six participants) were White British. Therefore, the findings generated above largely stem from these viewpoints, with the nuances of other ethnicities being absent.

Moreover, another limitation of this study pertains to potential recall bias which may have been at play as participants were diagnosed, on average, three years and six months prior to the interview. Whilst this allowed a longer-term exploration of participants’ experiences, this may have led to participants not remembering previous events accurately or led to them omitting certain details which may have been relevant to their experiences of being diagnosed. To mitigate the researcher provided prompts where necessary, although most participants appeared to talk freely, coherently and at length about their experiences. Additionally, ADHD services may have changed since participants were interviewed to it is possible experiences today may be different to three years ago.

Finally, an intersection not explored within the current study is social class or socio-economic status. This is particularly relevant since this study excluded those who received a private diagnosis and whose experiences might be quite different. Data on the participants’ level of education and employment status would also have been insightful.

### **Future research**

First and foremost, this study echoes the recommendation of Morgan (2024) who highlighted the need for further research to better understand the intersection of ethnicity and an ADHD diagnosis. Additionally, the social stigma surrounding ADHD within these communities may cause individuals to ‘mask’ or hide their behaviour due to fear of reprimand or ostracisation (Olaniyan et al., 2007). Documenting these experiences will help tackle current epistemic injustice in this area by allowing individuals from

these ethnicities to be representative in research, which in the long term may improve more accurate and timely detection of ADHD (Asherson, 2012).

Further research is also needed on the intersection between ADHD and other identities. For instance, this study sampled cis-gendered women who were assigned female at birth, therefore excluding transgender and gender-diverse individuals. As recently highlighted by Goetz and Adams (2024), there is a noticeable gap in research that has explored, both qualitatively and quantitatively, the experiences of ADHD among transgender and gender-diverse, with initial research suggesting an increased prevalence of ADHD within this population. This research may have significant implications for the way we understand ADHD and may allow for more inclusive assessments and evaluations.

Menopause is a chronically underfunded and understudied phenomenon which impacts up to 50% of women worldwide (The Lancet, 2022). In the context of participants' experiences of worsening ADHD traits, further empirical research is needed to explore the interplay between hormonal changes and ADHD, particularly during periods of hormonal fluctuations or changes such as menopause and following childbirth. This could include qualitative research that examines the lived experiences of People Assigned Female at Birth (PAFAB); grounded theory to gain insight into some of the social processes experienced by this population; and longitudinal mixed methods research, investigating the development of traits and coping over time. Experimental design could explore the impact of therapeutic interventions, including pharmaceutical options, social prescribing, and adapted talking therapies. This knowledge may facilitate the development of interventions, whilst also informing practitioners on ways in which medication may need to be titrated to help women manage worsening difficulties. Furthermore, this clarification may illuminate the biological factors which, alongside the psychological and social factors, may lead to the underdiagnosis of women and girls, allowing us to better tackle this issue.

### ***Implications and recommendations***

This study advocates for increased training for multiple professionals across different settings including teachers, GPs, and mental health professionals, on the ways in which ADHD symptoms may manifest in girls and women. It further advises the use of an intersectional lens within these trainings, shedding light on how aspects such as multiple points of oppression in one's identity may shape the lived experience of ADHD. It is hoped that increased training will facilitate compassion and empathy, preventing the experience of being misunderstood and dismissed by professionals. Furthermore, understanding the presentation of ADHD in a more holistic yet comprehensive manner will allow practitioners to better distinguish between diagnoses, and consequently reduce the number of women and girls getting 'missed'. Given the high rates of distress experienced by participants, it is hoped that this would also ensure that diagnoses are made promptly and in a timely manner, allowing for access to support and treatment.

This study also chimes in on the concern of the current state of ADHD adult services advocating for the need for increased funding across the board. Services and practitioners should be aware that individuals who have had the lived experience of ADHD diagnosis in adulthood may also have prior experiences of being rejected and dismissed by

**Table 3.** Summary of key recommendations.

| Individual Aimed At  | Training/Intervention  |
|--|--|
| GPs  | <ul style="list-style-type: none"> <li>• Training on how ADHD may manifest in women and girls, and how this may differ to the stereotypical understanding of ADHD.</li> <li>• The topics of diagnostic overshadowing and co-occurrences as well as the ways in which intersecting identities shape the lived experience of ADHD should be addressed.</li> <li>• Incorporating ADHD and neurodiversity training into GP and medical school trainings.</li> </ul>  |
| Teachers/Educators   | <ul style="list-style-type: none"> <li>• Training on how ADHD may manifest in school-based contexts.</li> <li>• Similar to GPs, the intersectionality framework may aid teachers in understanding how the intersection of various identities may shape the lived experience of ADHD and symptom manifestation.</li> </ul>  |
| Parents/Caregivers   | <ul style="list-style-type: none"> <li>• Training aimed at raising awareness, reducing stigma, and providing parents with the opportunity to better understand how they can support their children following an ADHD diagnosis.</li> </ul>   |
| Therapists, mental health practitioners, healthcare services | <ul style="list-style-type: none"> <li>• Training aimed at equipping practitioner with the necessary insights for them to be able to recognise and query an ADHD diagnosis in clients.</li> <li>• Practitioners may further benefit from learning about ADHD through an intersectional lens, highlighting that experiences are not monolithic.</li> <li>• Therapists may also benefit from learning about ways in which they could adapt their therapeutic approach for neurodivergent clients.</li> </ul> |
| ADHD assessors   | <ul style="list-style-type: none"> <li>• Training aimed at highlighting the impact that past experiences of help seeking may have on women who seek out a diagnosis in adulthood.</li> <li>• Further training to ensure that assessments are neuro-affirmative, and enquiry is compassionate.</li> </ul>   |

professionals. This rejection may impact current help-seeking and may foster feelings of mistrust or fear of re-rejection. A compassionate, person-centred, non-judgmental, neuro-affirmative approach towards individuals may facilitate regaining trust, giving room for feelings of connection and empathy to develop.

Moreover, the findings of this study also highlight the need for further support following diagnosis. If screened positive for ADHD, participants must receive access to support (both psycho-social and medication-based) promptly. Having a safe, non-judgmental, neuro-affirmative space may facilitate the processing of these emotions, reducing the distress experienced by individuals at this time. Support groups may be particularly helpful as they foster a sense of connection with a community of others. Support provided following diagnosis must be equal to all diagnosed via the NHS, with the need for seamless care as participants transition through various stages (i.e. pre-diagnosis, diagnosis, post-diagnosis). A summary of key recommendations is presented in [Table 3](#), below.

## Conclusions & contributions

The findings of this study revealed the different ways in which biological (e.g. hormonal changes), psychological (e.g. co-occurrences and diagnostic overshadowing), and social

experiences (e.g. stigma) all contributed to the picture, when it came to the experience of having an ADHD diagnosis in adulthood. Moreover, it also sheds light on the participants' perceived negative impact of a late diagnosis, along with the various systemic barriers currently in place – such as high waiting time for a diagnosis and unequal access to care across the country.

Finally, this study illuminated the journey of profound identity reconstruction and assimilation following ADHD diagnosis in adulthood. Participants' experiences also revealed that they were navigating their ADHD diagnosis in the context of their other identities, such as being a woman, being a mother, and/or holding a cultural identity. By foregrounding participants' experience, this paper highlights targets for policy development and change.

### Ethics approval statement

This study was approved by the City Research Ethics Committee (approval no. ETH2223-1674) on January 03, 2024.

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