

LIVING AS A WOMAN WITH ADHD: EXPERIENCES, CHALLENGES, AND ADAPTIVE
STRATEGIES

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Abstract

The purpose of this study was to explore how women living with an ADHD diagnosis coloured their experiences throughout life. Women continue to be excluded from clinical research and ADHD is a diagnosis that suffers from a significant male bias. As such, there is limited research about women with ADHD. This study employed a thematic analysis approach, inspired by grounded theory. Four women were recruited online after confirming they met criteria. The four women were interviewed with a semi-structured interview protocol, permitting for organic follow-up questions. Data analysis resulted in the identification of the following 4 themes: Negotiating and navigating education; Experiences of mental health; Socioemotional implications of having ADHD; and Strategies used to cope with ADHD. A total of 11 sub-themes were also identified and were correspondingly organized under appropriate main themes. This research is relevant to any professional working with women with an ADHD diagnosis or who may be querying an ADHD diagnosis.

Keywords: ADHD, women, thematic analysis, lived experience

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PART ONE

Introduction

Women in Canada face significant inequality as it relates to their health and wellness. Despite the fact that women tend to outlive men, women are also subject to a greater number of long-term and chronic illnesses which undoubtedly affects one's quality of life (Abdelaziz, 2007; Bushnik, 2016). For example, women are two times more likely than men to be diagnosed with depression (Canadian Women's Health Network, n.d.). Unfortunately, women's health concerns are consistently ignored or brushed off, leading women to feel dismissed and undervalued by their healthcare professionals (Barnack & Chrisler, 2007; Johnson & Johnson, 2006). This is in conjunction with the appalling lack of medical research on women's health (Holdcroft, 2007; Westervelt, 2015).

Within the field of counselling psychology, professionals are expected to provide ethical service to a diversity of individuals with various psychological and psychiatric presentations. According to the Code of Ethics published by the Canadian Counselling and Psychotherapy Association (CCPA) (2020), counsellors/therapists are expected to provide fair and equitable service while also "continually [seeking] to enhance their diversity awareness, sensitivity, responsiveness, and competence" (p. 8) as it relates to themselves and their clients. One method of doing so is engaging in scholarly practices and seeking out new knowledge to expand counselling competency. However, in the case where a phenomenon is under-researched, counsellors/therapists may find themselves in a difficult situation. As such, the following research responds to this need by focusing on an area of research that is presently underrepresented in the literature.

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One mental diagnosis among women that counsellors/therapists may frequently encounter, and which continues to be severely understudied, is that of Attention Deficit/Hyperactivity Disorder (ADHD). This disparity in research practices and knowledge surrounding ADHD in women motivates a need to act efficiently, effectively, and responsibly, as is the ethical duty of counsellors/therapists (CCPA, 2020). To this end, I pose the following research question: “What are the experiences of adult women living with an ADHD diagnosis, including the challenges associated with and the strategies used to adapt to such a disorder?” Due to the nascent nature of this field of study, the question will focus specifically on women’s experiences in the contexts of healthcare, education, work life, and family life. The purpose of this research is to provide a better understanding of women’s lived experiences with ADHD, with the ultimate goal of forming a valuable knowledge base that can be accessible by counsellors/therapists when they work with clients with this specific presentation.

Defining the Issue

Attention deficit hyperactivity disorder (ADHD) research is exceedingly inadequate with regards to women’s experiences. The lack of research is so vast that even the prevalence of girls and women who suffer from ADHD is unknown (CHADD, 2020). ADHD generally presents itself during early to middle childhood, with most diagnoses resulting in school-aged children (Hasan, 2017). According to Heidi Bernhardt (2019), symptoms of ADHD include difficulty regulating attention, inability to sit still for any length of time, and impulsivity.

At present, boys are diagnosed three times more than girls with ADHD (Bernhardt, 2019) with approximately 75% of diagnoses occurring in the male population (Singh, 2008). However, by adulthood, men and women are almost equally diagnosed with the disorder (Bernhardt, 2019).

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Deductively, this points to a potentially detrimental practice of underdiagnosing girls and a different presentation of the disorder among girls.

Without the support of research and society acknowledging the struggles women face with an ADHD diagnosis, these women suffer in silence (Waite, 2010). Better knowledge of the clinical manifestation of ADHD among girls and women could lead to a more clinically responsible approach of diagnosing this population sooner, with the potential of reducing the rate of women with ADHD struggling later in life. However, considering the immense lack of research on the topic, it is difficult for anyone to develop or provide support for women struggling with this disorder, which brings us to the research question at hand. Understanding that women with ADHD are the experts of their story and experiences, I have adopted a qualitative approach as I explore the topics that are central to my thesis research.

Thesis Structure

In the next section, I will provide a thorough review of the literature as it relates to my research question. The presented research will describe and conceptualize ADHD as a disorder, including etiology, symptoms, and diagnostic impact on individuals. Furthermore, the literature review will examine research that is adjacent and pertinent to the question at hand, namely women's experiences with healthcare and at work. Also included is an examination of gender and how it relates to and colours ADHD etiology and symptomatology. Part 3 describes the conceptual framework of the study – that is, an intersectional, feminist perspective – and subsequently establishes the theoretical underpinnings behind the construction and conduction of the thesis research. Part 3 also defines the methodology used, highlighting an adapted version of grounded theory in a thematic analysis framework, in addition to a description of the methods. In Part 4, an analysis of the results is presented as a grouping of themes and subthemes that shed

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light on the content of participants' narratives. Lastly, but certainly not least, Part 5 delivers a wholistic critical reflection of the study by deriving meaning from the results with reference to the previously discussed literature. Rounding out the research, the chapter concludes with a discussion of the limitations, contributions to the current knowledge base, and future directions for this line of study.

PART TWO

Review of the Literature

As problematized in the previous chapter, women consist of a consistently under-researched population when it comes to the literature regarding attention-deficit/hyperactivity disorder (ADHD). Considering the lack of attention women experience regarding their health, the topic merits further investigation, thus leading to the ultimate question: How do women with ADHD experience their diagnosis in their life? The question will be anchored more specifically by a thorough literature review of pertinent concepts. The aim is to provide a relatively exhaustion conceptualization of ideas that are foundational to the research question that has been posed.

Conceptual Framework

When evaluating the experiences of women and their health, it is crucial to maintain some awareness of intersectionality. Crenshaw's (1991) intersectionality describes the dimensionality of people's experiences, as influenced by not one but multiple identities as they pertain to the individual. There are five types of intersectionality: 1) Structural intersectionality, which occurs when social structures organize and create unintended consequences; 2) Political intersectionality, which occurs when social justice movements organize for positive change and exclude an important subset of a group, thereby reinforcing the very social injustice they seek to dismantle; 3) Representational intersectionality, occurring when certain images exist to represent a group and result in distorting the group's true complexity; 4) Experiential intersectionality, which describes how belonging to multiple social groups cannot be deconstructed as experiencing each social group singularly; and 5) Intersectionality identity, which simply describes a person's identification with an intersectional group. Hankivsky (2012) argues that

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gender should not be conflated with women's health and that, in fact, being a woman is only one facet of a negative medical experience. Nevertheless, by adopting an intersectional approach, researchers and policymakers are better able to evaluate the very real existence of women's health disparities.

ADHD: Diagnosis, Etiology, and Outcomes

ADHD is a neurodevelopmental disorder that generally emerges during childhood and is characterized by symptoms of impulsivity, an inability to focus, and hyperactivity (Maniadaki & Kakouros, 2017; Volkow & Swanson, 2013). However, even while ADHD is most commonly diagnosed during childhood, adults are increasingly being diagnosed with the disorder (Wilens et al., 2009). Approximately 8.4% of children and 2.5% of adults have ADHD (Parekh, 2017). Because there is no laboratory test to determine if an individual has ADHD, information from family and teachers is usually collected in addition to completing checklists to ascertain that the person in question is being accurately diagnosed (Parekh, 2017).

An individual can be diagnosed with one of three types of ADHD: 1) inattentive type; 2) hyperactive/impulsive type; or 3) combined type and is required to meet either 5 or 6 of the criteria, depending on age (CDC, 2019; Volkow & Swanson, 2013). Symptoms will vary (Bernhardt, 2019). Predominantly inattentive type is characterized by persistent inattention, which includes symptoms such as making careless mistakes, producing messy and disorganized work, a lack of follow-through, forgetfulness, and sudden attention shifts during social situations (e.g., conversations with other people) (Fisher, 2013). While it may appear an individual with predominantly inattentive type might not complete tasks due to being oppositional, this is not the case; in fact, the sustained mental effort required to complete the task is difficult to maintain and therefore unpleasant for the individual (Fisher, 2013).

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For someone with predominantly hyperactive-impulsive type, their hyperactive symptoms manifest often as an inability to remain seated, excessive athletic demonstration (e.g., running) at inappropriate moments, and rapid and excessive verbalization (Fisher, 2013). Symptoms of impulsivity are often expressed as impatience, blurting out answers, and interrupting conversations (Fisher, 2013). In order for an individual to be diagnosable with ADHD, they must meet the base threshold of at least 6 persisting symptoms of one of the above types for at minimum a 6-month period (Fisher, 2013). In the case of predominantly inattentive type, the individual must present with fewer than 6 hyperactive-impulsive symptoms over a 6-month period and vice versa with regard to predominantly hyperactive-impulsive type (Fisher, 2013).

ADHD as a disorder in the clinical field has faced significant controversy despite growing international recognition since 2000 (Maniadaki & Kakouros, 2017). While it remains a continually revised and updated entry in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V), there nevertheless exists a debate arguing that ADHD is a construction of the pharmaceutical industry and/or culturally/environmentally influenced (Maniadaki & Kakouros, 2017). The debate stems largely from the fact that ADHD diagnoses have hugely increased since the 1990s (Tait, 2005). According to Tait's (2005) review of the three camps of the debate, the first group very clearly believes in ADHD as a diagnosis in its own right, the second posits that while ADHD may exist, it remains overly-diagnosed, and the third camp advances that ADHD does not exist in its own right, due to any one of three reasons: 1) the financial interest of pharmaceutical giants; 2) that ADHD is merely an amalgam of juvenile misbehavior; or 3) is the manifestation of a cultural or political construct. However, as Wetzel (2010) aptly remarks, many disorders related to mental health have been criticized

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because of the inability to diagnose through medical testing. It remains clear that the research and literature widely acknowledges ADHD as a valid disorder, even in spite of some perceived shortcomings by those who disagree.

The exact causes of ADHD are somewhat unknown, although it is clear that there is a strong genetic component involved (CDC, 2019; Bernhardt, 2019; Hasan, 2017; Parekh, 2017). Waldman and Gizer (2006) consider some dopamine, norepinephrine, and serotonin neurological transmitter systems to play a partial role in the etiology of ADHD. Neurologically, through structural imaging techniques, ADHD has shown to affect the frontoparietal executive control network (Robaey et al., 2016). The research generally points to little-to-no environmental factors influencing the development of ADHD (Waldman & Gizer, 2006). Some evidence points to alcohol and drug use during pregnancy, brain trauma, and exposure to toxins as causes of ADHD (National Institute of Mental Health, n.d.). Researchers and scientists are exploring possible causal relationships between ADHD and brain injury, environmental factors, and premature birth among others (CDC, 2019). Another study conducted by Starck, Grünwald, and Schlarb (2016) found that while approximately 50% of parents of ADHD children also had an ADHD diagnosis, there was no correlation of diagnoses between parents and children. ADHD can affect people in all spheres of their life and may present itself through low academic scores, an inability to complete household chores in a timely manner, and/or not paying enough attention when in public spaces (National Institute of Mental Health, n.d.).

According to Maniadaki and Kakouros (2017), ADHD is a disorder that can have serious implications across all domains of a person's life and can predispose an individual to developing comorbid disorders and other adversities, such as diminished academic performance or fractured

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interpersonal relationships. The reason for this lies in the evidence of social skills deficits among children who have been diagnosed with ADHD (Parke et al., 2018).

Parke and colleagues (2018) conducted a study examining the social cognition of children with ADHD, particularly with regards to affect recognition, theory of mind, pragmatic language ability, and cognitive empathy. Parke and colleagues found that children with ADHD were low in these social cognitive factors compared to children without such a diagnosis, which would indeed affect normal daily functioning in social situations (2018). A lack of appropriate social skills can subsequently lead to rejection among peers and other instances of difficulty interacting with peers (Humphreys, Galán, Tottenham, & Lee, 2016). Because this difficulty will arise at a young age and without proper support and management, children with ADHD risk growing up to develop comorbidities, such as substance abuse, depression, and social anxiety (de Boo & Prins, 2007; Paulson, Buermeyer, & Nelson-Gray, 2005; Tseng & Gau, 2013). In fact, Humphreys and colleagues established evidence for the fact that baseline symptoms of ADHD were predictors of social problems after two years, specifically in terms of understanding affective social cues (2016).

On the contrary, there also exists a negative bias towards individuals with ADHD, resulting in peer rejection (Canu, Newman, Morrow, & Pope, 2008; Paulson, Buermeyer, & Nelson-Gray, 2005). This effectively positions individuals with ADHD at a disadvantage when seeking to develop positive and fulfilling social relationships (Canu, Newman, Morrow, & Pope, 2008). Clearly, if not properly treated and supported, individuals with ADHD may face a difficult road ahead marked by challenges both professionally and personally.

Evidently, considering the overview provided above, ADHD is a disorder that is serious in nature and can pose significant consequences and complications for affected individuals if not

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responded to appropriately. Untreated, ADHD can have wide-reaching negative implications regarding proper social and affective functioning for the individual. However, these consequences hold the potential to run deeper when looking specifically at women within the population of those diagnosed with the disorder. The reasons for this are many and varied, largely stemming from historical practices of excluding women from clinical research, in addition to sexism and the marginalization and oppression of women in North American society. Indeed, being a woman aggravates the already serious and potentially detrimental impacts ADHD can pose. Thus, as a service to ADHD clinical research and those women affected by the disorder, it is crucial to further investigate the situation surrounding adult women who have lived experiences with an ADHD diagnosis.

Women and Healthcare

The history of women's inequality is undoubtedly one that stretches far back and, while in modern times, progress has been made through the creation of the UN Declaration of Human Rights and the 1975 inaugural UN World Conference on Women, women's issues still remain at the forefront of North American society (Equitas, n.d.). According to Politico Magazine (2019), women in North America still face discrimination associated with the glass ceiling, patriarchal practices and customs, economic inequality, and violence, to name just a few. In 2018, the Canadian Women's Foundation published a report that found evidence for continued systemic inequality aimed at women (Hill, 2018). All of this points to alarming trends and a potentially harmful lack of attention towards women's issues, particularly as women alone make up 50.4% of Canada's population (Status of Women Canada, 2012).

Within Canada, women continue to experience discrimination in all facets of life (Canadian Human Rights Commission, 2013). Professionally, work remains largely segregated

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by sex. This has been a centuries-long pervasive issue globally (Haynes, 2017). As of 2017, Canadian women outnumber men doing paid service work (e.g., teaching, nursing, clerical/administrative work) and, by 2015, women held the greatest share of employment in industries like healthcare and social assistance, education, and retail and food services (Moyser, 2017). The COVID-19 pandemic has further exacerbated stressors for women in the working world (Bateman & Ross, 2020). Furthermore, within any of the positions that women find themselves in, they tend to make less money when compared to their male counterparts. According to the Canadian Feminist Alliance (2008), women in Canada with full-time employment make only 71% of what men make in the same job – and it has nothing to do with education levels either: university-educated women still only make 74% of what their male counterparts do in the same position. This is despite the fact that 34% of Canadian women hold tertiary degrees compared to 29% of men (Catalyst, 2019).

Within the company of one's own home, women consistently perform 50% more domestic household tasks than men and spend twice the time on childcare (McCann Worldgroup Canada, 2018). Thus, it is no surprise that 40% of Canadian women feel that they have no assistance with the work they do at home. Moreover, by 2009, 76% of women in the workforce were married or living common-law – this means that women are increasingly taking on multiple roles both at work and at home (Spinks & Battams, 2015). Coupled with the high percentage of women who are also working outside of the home, a whopping 72% of women in Canada feel the burden of work-life balance (McCann Worldgroup Canada, 2018).

Women also face significant inequality with regards to the Canadian healthcare system. Even while women tend to outlive men, women are also subject to a greater number of long-term and chronic illnesses which undoubtedly affects one's quality of life (Abdelaziz, 2007; Bushnik,

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2016). For example, women are two times more likely than men to be diagnosed with depression (Canadian Women's Health Network, n.d.). Women are also more likely to develop multiple chronic conditions when compared to men (Bierman et al., 2009). Unfortunately, women's health concerns are consistently ignored or brushed off, leading women to feel dismissed and undervalued by their healthcare professionals (Barnack & Chrisler, 2007; Johnson & Johnson, 2006). According to Laura Kiesel (2017), women and their health problems continue to be downplayed or outright dismissed by doctors. This is in conjunction with the appalling lack of medical research on women's health, even while men typically consult with medical professionals less than women (Holdcroft, 2007; Wang et al., 2013; Westervelt, 2015).

While the marginalization and oppression of women has persisted over centuries, such as when "female hysteria" was a common diagnosis in the 19th century for women experiencing unorthodox medical problems, the real beginnings of the exclusion of women from clinical trials and clinical research overall began in 1961 with the thalidomide tragedy (Flynn, 2019; Oertelt-Prigione, 2011). Thalidomide is a sedative drug and human teratogenic originally prescribed to treat morning sickness among pregnant women, among other illnesses (Prommer et al., 2011; Thalidomide Victims Association of Canada, n.d.). The use of thalidomide caused irreversible and sometimes life-threatening birth defects for the children of over 10,000 pregnant women involved in the 1961 trials (Oertelt-Prigione, 2011; Thalidomide Victims Association of Canada, n.d.). Following the tragedy, all fertile women – pregnant or not – were banned from participating in any future clinical trials (Oertelt-Prigione, 2011). Certainly, the thalidomide tragedy led to a greater fear among researchers and scientists in running trials that included women.

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Oertelt-Prigione (2011) acknowledges that, following the 1961 thalidomide tragedy, it was also discovered that there are fundamental biological differences (i.e., hormonal differences) in women that can lead to typically female adverse side-effects in clinical trials. In this sense, the participation and regulation of women in research and clinical trials is more complex. Holdcroft (2007) further addresses other reasons for the gender disparity in health research, including lack of research funding for studies focusing on women's health and reporting of gender-related data in research. However, the lack of gender-minded research remains only one side of the issue about gender-based bias against women.

In the professional medical context, barriers to service for women seeking help persist. These include barriers to progress across institutions, such as poor training, a lack of awareness about gender issues and differences, and power dynamics (Morgan, 2018). Women's experiences and symptoms are often explained away on the basis of being psychosomatic, leading them to stop seeking medical assistance once they realize medical professionals are not addressing their concerns seriously (Flynn, 2019). When women do seek medical assistance, they are consistently prescribed less medication (Flynn, 2019). Furthermore, the gender-based bias against women in medical contexts is further compounded by differences in race and ethnicity (Flynn, 2019).

Women continue to be neglected and dismissed by their healthcare professionals (Kiesel, 2017). An estimated 83% of women feel that they have experienced gender-based discrimination from their medical providers (Pagán, 2018). Recent research in fact points to the existence of a gender pain gap which is being ignored by both medical professionals and people involved at the policy level (Bernardes, Keogh, & Lima, 2008; Bustreo, de Zoysa, & de Carvalho, 2015; Tashani, Alabas, & Johnson, 2012). According to Tashani and colleagues (2012), there are biological reasons that contribute to women physically experiencing more pain than men, and

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this may be largely due to the fact that women experience more eventful reproductive lives than men – that is, they are subject to pregnancy and a slough of hormones over the course of their life. For example, nearly 40% of women in the United Kingdom experience urinary incontinence and/or uterine prolapse following the delivery of a child (Peate, 2016).

However, Bustreo and colleagues (2015) make the point that even while women have more active medical lives than men in the sense that they are subject to medical interventions more often because of their sex and gender, there is a paucity of structural support in both clinical and political settings. For example, one study conducted at a Swedish hospital found that women felt they were unable to question medical advice due to the relatively toxic power dynamics between medical provider and patient (Wolf, 2014). Wolf's qualitative study allowed women to comment on their experiences in a medical setting and, using grounded theory techniques, established a core category of 'the patient loses power struggles'. Under this core category, four subcategories emerged: 1) patient's vulnerability; 2) staff domination techniques; 3) patient's competence; and 4) structural limitations (Wolf, 2014).

Women's mental health also suffers a lack of support from clinicians and structural supports alike. The US Office on Women's Health (2019) asserts that in any given year, 1 in 5 women suffer from a mental health condition, commonly depression, anxiety, and/or bipolar disorder which all disproportionately affect women more than men. The gender disparity regarding mental health conditions has a lot to do with women's subordinate social status and other factors such as the epidemic of gender-based violence towards women (WHO, n.d.). Through the intersectional lens discussed above, women's health will be able to be understood and evaluated while taking into consideration the nuanced factors by which it is negatively influenced, particularly in reference to Attention-deficit/hyperactivity disorder (ADHD).

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Ultimately, gender bias against women remains alive and well in the field of medical and clinical research and practice. This bias acts as an impetus for further exploration of women's experiences with diagnoses and healthcare and, as such, the proposed study will explore Attention-deficit/hyperactivity disorder (ADHD) as it relates to women and their experiences, including challenges faced and the strategies used to respond to said challenges.

ADHD and Women

The lack of research on ADHD in women is so vast that even the prevalence of females who suffer from ADHD is unknown (CHADD, 2020). ADHD generally presents itself during early to middle childhood, with most diagnoses resulting in school-aged children (Hasan, 2017). According to Heidi Bernhardt (2019), symptoms of ADHD include difficulty regulating attention, inability to sit still for any length of time, and impulsivity.

The impacts of underdiagnosis of ADHD among girls are far-reaching. Generally, individuals regardless of gender who are diagnosed with ADHD later in life are more likely to present with psychiatric comorbidities (Ginsberg et al., 2014). Worse, adults with untreated ADHD often experience poorer clinical and functional outcomes when compared to adults receiving treatment for their diagnosis (Ginsberg et al., 2014). ADHD among girls and women has gradually taken on the characteristics of a "hidden diagnosis", which speaks to the different ways in which the disorder manifests depending on gender (Quinn, 2005). Quinn (2005) also states that females with undiagnosed ADHD are more likely to engage in high-risk behaviours, such as sexual promiscuity and substance abuse when compared to their male counterparts. Existing with this hidden diagnosis ultimately hampers girls' and women's abilities to lead successful lives, unless they receive the clinical attention and supports necessitated by having ADHD. Better knowledge of the clinical manifestation of ADHD among girls and women could

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lead to a more clinically responsible approach of diagnosing this population sooner, with the potential of reducing the rate of women with ADHD struggling later in life.

In fact, ADHD symptomatology and presentation differs between sex and gender. Girls and women are more likely to be misdiagnosed with depression instead because of the fact that they are more likely to present with depressive symptoms as a result of ADHD (Bernhardt, 2019, CHADD, 2020). Furthermore, girls with ADHD might present with more severe attentional and intellectual difficulties and less hyperactivity and misconduct than male counterparts (Arnold, 1996). Because of the lack of support structure available for women who struggle with ADHD, these women are more likely to develop comorbid substance use disorders and/or chronic illnesses (CHADD, 2020). Obviously, with a late diagnosis, women with ADHD are more at risk. Further considering the added societal pressures from society that are placed on women, certainly the compounding factor of living with an ADHD diagnosis inevitably adds to life stress.

Considering the above, it is clear that they remain marginalized not only by society, but also by the clinical research. Women in general already face challenges at work and at home as they attempt to balance competing demands from both environments. The stress of this is further compounded by the apparent neglect of their health needs in both clinical and research contexts and specifically ADHD, as it relates to the study at hand. Taking into consideration all the above listed stress factors, the necessity for further research exploring the experiences of women with ADHD becomes clear. The parameters of the question posed for this research include an exploration of how an ADHD diagnosis impacts women's lives and the various strategies and other resources used to overcome the challenges of ADHD.

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Having thoroughly reviewed the literature above, it is certain that ADHD as a diagnosis is a serious illness that can have profound impacts on the individual affected. While acknowledging the real effects ADHD symptoms can have on the diagnosed, including difficulty paying attention or seeing tasks through, ADHD also poses implications on other aspects of the affected's life. For example, ADHD as a diagnosis is burdened with a stigma which can lead to discrimination. People with ADHD might struggle to make friends because of the social discrimination they experience. Furthermore, as women are underrepresented in the ADHD research, they face further discrimination in finding support, social and/or medical, for their diagnosis because of the compounding marginalizing factor of gender. This has led to a paucity of research focusing on understanding and supporting women who live with an ADHD diagnosis. Thus, the need for an exploratory study into the experiences of women living with an ADHD diagnosis is more than evident.

Without the support of research and society acknowledging the struggles women face with an ADHD diagnosis, these women suffer in silence (Waite, 2010). According to Worth (n.d.), struggles often arise because the woman's ADHD diagnosis comes into conflict with society's expectations for women to be well-organized and keeping track of things. However, considering the immense lack of research on the topic, it is difficult for anyone to develop or provide support for women struggling with ADHD, which brings us to the following question: What are the experiences of adult women living with an ADHD diagnosis, including the challenges associated with and the strategies used to adapt to such a disorder?

The question seeks to identify the specific experiences of individual adult women who are living with an ADHD diagnosis, either diagnosed during childhood or later on. The question is relevant to present society as its aims are twofold: 1) to shine a light on the existence of

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women who are diagnosed with ADHD and how they live with their diagnosis; and 2) elucidate the challenges faced and strategies used to adapt to said challenges. Ultimately, hopeful outcomes will provide greater acknowledgement of women living with ADHD and how their lives play out as they battle the dynamics of both gender and mental wellness. The study will shed an exploratory and holistic look at the lived experiences of women diagnosed with ADHD, including the challenges they face and the strategies they have developed to adapt.

CHAPTER THREE

Methodology

Essentially, it is the study's topic that ultimately determines the methodology used. Considering the nature of the research study which focused on exploring phenomena related to women's experiences with an ADHD diagnosis, it was apt that the research methodology aligned with qualitative practices. In other words, quantitative data did not take precedence; instead, the value of the data and results stemmed from the narratives and dialogues of recruited woman participants who align with specific criteria. While a quantitative approach to research methodology typically emphasizes the importance of objective and observable facts, such an approach can also limit the researcher significantly in being able to adequately grasp the holistic reality of an individual's experience with a certain phenomenon (Tomiak et al., 2007). On the contrary, a qualitative approach with an emphasis on the holistic-inductive paradigm emphasizes the importance of the subjective, thus allowing for the researcher to bear witness to a less fragmented reality of the phenomenon experienced (Hesse-Biber, 2017; Tomiak et al., 2007). In other words, with this approach, a researcher attempts to understand the experience in question through the participant's natural and subjective perspective. For these reasons, a qualitative methodology mostly aligned with the holistic-inductive paradigm was deemed most appropriate for the study in question.

More specifically, an adaptation of grounded theory was used as the foundational methodology in this study. Grounded theory enables the researcher to examine and explain the underlying processes of a social phenomenon through the close identification of patterns between categories and concepts, as influenced by the perspectives of participants (Turner & Austin, 2021). When employed fully, grounded theory depends on simultaneous data collection and

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analysis and the development of codes without a presupposed hypothesis. Notably, sample sizes in studies utilizing grounded theory are established when theory construction is deemed satisfactory and not for the purposes of population representation (Glaser & Strauss, 1967). However due to some limitations, including time constraints, the need for convenience sampling, and the variety of challenges posed by the COVID-19 pandemic to research in general, grounded theory in its full form was not appropriate this study. Additionally, grounded theory in its pure form can pose the risk of producing results that are conceptually complex and/or confusing for both the drivers and consumers of the research. For these reasons, a thematic analysis framework was deemed necessary, especially due to the flexibility that it affords the researcher (Braun & Clarke, 2017). It should be noted that thematic analysis is not one approach, but rather a method that can be applied to a methodology (i.e., grounded theory) (Braun & Clarke, 2016).

As informed by Braun and Clarke (2012), thematic analysis utilizes a bottom-up approach to data analysis to empower the development of themes by each participant. In terms of units of data, codes are developed as the smallest units that essentially capture a snapshot of a potentially interesting data feature (Braun & Clarke, 2017). In turn, codes inform the creation of themes which allow the research to present a unified and logical framework for reporting the researcher's analysis (Braun & Clark, 2017). Some of the benefits of thematic analysis include the flexibility it provides, as previously mentioned above, particularly as it pertains to the research question(s), sample size, how data is collected, and how meaning is extrapolated from the data (Braun & Clarke, 2017). Furthermore, as the research topic of this study is historically and presently under-researched and underrepresented in the literature, it is necessary that the study assumes an exploratory research orientation, and this is facilitated by the use of thematic analysis (Hesse-Biber, 2017).

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Thematic analysis is also accessible to researchers and the study's audience. As noted above, grounded theory that is utilized fully in a study can be overwhelming for all involved (Braun & Clarke, 2012). Because the nature and aims of this study are to examine and shed light on a topic that is underrepresented in literature and social contexts, the audience is multifold and includes not only academics but also members of the general public. Thus, it is of the utmost importance that the research methods used are understood easily by all.

Participants

In total, there were 4 interviews conducted with four women-identifying participants who met the inclusion criteria set forth for the study. Interviews were conducted virtually on the web-based videoconferencing platform Zoom, between the months of February 2021 and May 2021. Table 1 below provides the demographic information of each participant and the pseudonym that was assigned to them. This demographic information was obtained from the participants during the demographic interview that directly preceded the research interview. The inclusion criteria in order for the participants to be included in the study was the following: 1) requirement to be between the ages of 18 and 65; 2) self-identification as a woman; and 3) an official medical diagnosis of ADHD. The diagnosis could have occurred at any time; what is important is that each participant had an official diagnosis from a medical professional. The age criterion intentionally included a large spread in an effort to allow for the potential to highlight similarities and differences that could arise despite age. A concerted effort was also made to select participants who were unknown to principal investigator to reduce bias. Additionally, no other inclusion criteria were specific (e.g., profession, education level, etc.) to reduce sample bias.

Of the participants, 2 were young professionals (younger than age 30), 1 was middle-aged in the middle of her career, and the final participant was at the end of her career. Three of the

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four identified being in romantic relationships, 2 of which were in same-sex partnerships. All participants reported possessing at least a bachelor's degree, and 1 participant possessed a master's degree. All participants reported working full-time and represented the following fields of work: technology (2), education (1), and international affairs (1). All had an official ADHD diagnosis from a medical professional, although each participant reported receiving this diagnosis at different points in their life – 1 participant received the diagnosis in middle-age, another during undergraduate study, and 2 participants received their diagnosis during grade school.

Table 1

Participant Profile

Participant	Age	Age when ADHD diagnosis received	Educational qualification(s)	Profession
Cora	60	53	Bachelor's degree	Teacher
Alma	21	15	Bachelor's degree	Engineer
Yvonne	41	5	Bachelor's degree; Master's degree	Consultant
Eliza	30	22	Bachelor's degree	Administrative assistant

Efforts to ensure and maintain confidentiality

To ensure confidentiality throughout the process, participants were randomly assigned pseudonyms and any other identifying information (e.g., place names, names of other people) were redacted. All transcribed interviews were only accessible to the researcher and supervisor. Transcripts, audio files, and consent forms have been securely stored on a password-protected, encrypted hard-drive in a locked file cabinet owned by the researcher and will be adequately destroyed 5 years after the initial data collection date.

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Interview

Prior to the interview, participants read and signed an informed consent form (see Appendix A) electronically. The informed consent included a description of the research study, including any and all possible risks and/or benefits.

The interview protocol itself was developed to be semi-structured to allow for flexibility and took place over the span of 45 to 60 minutes. This study, in particular, called for a semi-structured protocol as it permitted space for the researcher to probe further into participants' stories, beyond the initial interview structure. In this sense, the interviews benefit from a richness of narrative and content unique to individual participants. Noting that the study's focus was to explore the lived experiences of women with an ADHD diagnosis, this approach to the interview protocol was fitting.

The questions included in the protocol were created and selected through a process that was strongly informed through a thorough review of the literature on ADHD in women. With an understanding that the lived experiences of women with an ADHD diagnosis transcend different facets of life, the intention of the questions in the protocol were developed to gather information about the experiences of women living with an ADHD diagnosis in the context of professional healthcare, work, and home life, and the adaptive strategies employed to respond to the potential challenges elicited from these experiences. Hence, the protocol was ultimately divided into 4 sections: 1) Background with ADHD; 2) Healthcare Experience; 3) Experiences and Challenges at Work and at Home; and 4) Strategies. Such a divided structure was also fabricated to facilitate a narrative arc that logically flowed during the interview process. The questions themselves were open-ended and broad, allowing each participant plenty of room and time to describe their

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experiences in detail. At times, I would respond with follow-up questions as part of the probing process, as mentioned above.

Procedures

Data collection

Prior to the initiation of data collection, the study was subject to approval by the University of Ottawa's Ethics Committee and receipt of a Research Ethics Board certificate (see Appendix #). Considering the physical and social limitations imposed by the COVID-19 pandemic at the time of this study, recruitment efforts relied heavily on the Internet and, more specifically, Facebook groups with limited membership for woman-identified people only. I shared a pre-drafted text to these groups which included information concerning myself as the researcher and a brief introduction of the study itself. The text specified any interested individuals to contact me as the researcher via e-mail. See Appendix # for an example of the text used in recruitment.

Upon receiving messages of interest from potential participants, I confirmed that each participant met the inclusion criteria. While many participants demonstrated initial interest, only 4 individuals maintained contact and followed through with the interview in its entirety. These 4 individuals were sent the informed consent and provided their electronic signatures prior to the scheduling of the interview. Each participant was provided with their own electronic copy of the informed consent and informed of the confidentiality measures in place for the purposes of the study. Participants had the option of either a phone interview or interview via secure Zoom platform – due to the COVID-19 pandemic and associated mandated safety protocols, in-person interviews were not an option. All participants opted for a video interview via secure Zoom platform.

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At the beginning of the interview, I reminded participants of the informed consent and their right to withdraw from the study at any point during or after the interview. I also invited participants to share any questions or concerns that they had regarding the study, at any point. Participants were also reminded that some of the interview questions had the potential to elicit emotional or mental discomfort and, if this were to arise at any point, participants were permitted to ask to pause the interview if needed. It should be noted that participants did not have present any questions or concerns pertinent to the study nor did any participant request the interview to be paused due to emotional or mental discomfort.

The start of the interview collected additional demographic information. The demographic information gathered was not for any statistical purposes, but rather to provide descriptive data of each participant to help further contextualize the unique experiences of each. The remainder of the interview followed the semi-structured format described above, utilizing open-ended questions. Each interview lasted approximately 45 to 60 minutes and the interview audio was recorded on a recording device, after which the audio file was transferred to a password-protected, encrypted hard drive in my possession only. At the end of the interview, each participant was informed that they were able to reach out to me with any questions any time after and that I would be in contact periodically throughout the remainder of the research process. Once interview audio was transcribed verbatim, each participant was e-mailed an encrypted PDF file of their interview transcript. Participants were allotted 7 days to review and return the transcript with any changes – it was made to clear that any changes or requests for changes were acceptable and would be honoured. No participant made changes to their transcripts. Participants were informed that they would receive a copy of the study via e-mail upon its completion.

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Data analysis

The data analysis procedure, as described above, fell under the framework of a thematic analysis that was simultaneously inductive and semantic. In other words, the analysis was completed with the data that was presented at face value and without inferring assumptions of underlying meaning to the participants' dialogue. An inductive analysis meant that the analysis was conducted without pre-developed data sets. Because a thematic analysis involves the coding of important words and phrases that are then attributed to emerging themes in the data, it was important for the integrity of the study that themes were not developed or hypothesized prior to the actual coding of the data sets. Lastly, an iterative comparison was done to ensure that the themes that emerged from the interviews were in fact valid results of the analysis.

To analyze the data, the 6-phase approach to thematic analysis established by Braun and Clarke (2006) was utilized. The phased approach includes the following steps, as outlined by Braun and Clarke: 1) Familiarization with the data; 2) Generation of initial codes; 3) Searching for themes; 4) Revision of themes; 5) Defining and naming themes; and finally, 6) Writing the report.

The first phase was the one in which verbatim transcription of each audio file took place. Once the transcriptions were complete, I read each one multiple times while taking notes of salient items of potential interest and to familiarize myself with each transcription. From there, I was able to move onto the second phase, which is the generation of codes which become the building blocks of the analysis (Braun & Clarke, 2012). For each transcription, this process entailed identification of section of text that could be relevant to the research, which then led to the application of preliminary codes. As new material arose, new codes were generated, and existing ones were subject to modification. The third phase involved the searching for and

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creation of themes; codes were reviewed for any thematic overlap and subsequently clustered based on the identified themes. The fourth phase allowed for the revision of themes by comparing against the data. The next phase was guided by the 3 criteria to define and name themes, as outlined by Braun and Clarke (2012): 1) themes have a singular focus; 2) themes are related but do not overlap; and 3) themes clearly address the research question(s) put forth. Finally, the last phase of the analysis involved writing up the results in a way that integrated the previous phases into a narrative that effectively responded to the research question.

Trustworthiness of Study

When conducting any study, it is crucial to ensure the quality of the study, including any associated methodology, data, and corresponding analysis. This is called trustworthiness and there are certain steps taken to ensure it. In particular, there are 4 criteria that have been developed to operationalize and ascertain the rigour of any qualitative study: 1) credibility; 2) dependability; 3) transferability; and 4) confirmability (Lincoln & Guba, 1985). Below, I will discuss how each criterion has been addressed throughout the length of the study in question.

Credibility

Credibility describes the truthfulness behind the data obtained from the participants as well as the truthfulness and accuracy of the researcher's interpretation of said data (Cope, 2014). It also relates to how the researcher positions themselves within the research itself, which is called reflexivity (as the researcher, I discuss my reflexivity later in this section). With the goals of credibility in mind, participants were invited to engage in member checks whereby they could verify the accuracy of their transcribed interviews and my interpretation of their content in vivo through the use of important counselling techniques, such as validation, paraphrasing, and reflecting (Hill, 2014). Participants confirmed the credibility of my interpretations and their

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interview transcriptions. I also took note of my own interpretations in a research journal as personal checks on my own biases and prejudices to ensure that interpretations were honest and accurate.

Dependability

Dependability speaks to the ability of a study to remain constant across similar contexts (Cope, 2014). In other words, the decisions and other activities or events that take place throughout the research process require detailed recording, in order to enable to future researchers to replicate the process. As evidenced by this paper, I have detailed a comprehensive report of all procedures undertaken, including but not limited to the research design, data collection, data analysis, and any pertinent information regarding the participants or myself as researcher. As is the case for the credibility criterion, a detailed description of a researcher's reflexivity (see below) further bolsters the dependability criterion.

Transferability

Typically, transferability is mostly relevant in studies that aim to make generalizable claims about a phenomenon or phenomena (Cope, 2014). As this was the case for the study in question, I endeavoured to ensure the transferability of the findings. In other words, the findings of the study should be applicable in other contexts and within or between other groups (Cope, 2014). Perhaps most importantly, transferability is deemed achieved if the readers can associate the results with themselves or others beyond the primary participants (Cope, 2014). To ensure this, the inclusion criteria was purposefully broad to permit the participation individuals from potentially diverse backgrounds. Detailed descriptions of background information regarding the study's questions, its participants, and the analysis were also included.

Confirmability

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This criterion guarantees that the results presented accurately reflect the participants' views and contributions and not the biases and prejudices of the researcher (Cope, 2014).

Ultimately, this is achieved by providing detailed descriptions of how conclusions were made and how interpretations were developed (Cope, 2014). For example, in this study's presentation of the results, I drew upon specific examples from interviews to underscore specific codes and certain themes. I also created an audit trail including every step taken through the research process. Furthermore, my thesis supervisor acted as an auditor and sounding board to ensure the rigour of the study and quality of results.

Reflexivity and Positionality of the Researcher

While other researchers in the field may somewhat debate or disagree with this standpoint, I believe that a researcher's reflexivity and positionality is simultaneously one of the most crucial and valuable components of studies depending on a qualitative methodology to obtain results. In some cases, researchers may refer to this as an auto-ethnography within the context of the study (O'Connor, 2011). The value of a researcher providing a statement of reflexivity and positionality as it relates to the topic of study lies in the fact that it offers prima facie evidence that the research process has been conducted with integrity, with the researcher acting systematically, skeptically, and ethically (O'Connor, 2011). In considering one's reflexivity and positionality, the researcher will typically address their social position within society (e.g., age, gender, race), personal experiences, and political and professional beliefs (Berger, 2015). Implicitly, the researcher recognizes the impact their self may have on any potential outcomes of the study at hand and the impossibility of avoiding this impact and its subsequent consequences (Berger, 2015).

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Anecdotally, a professor during my time as an undergraduate student in psychology once told me: “Almost all research is, in fact, ‘me-search.’” I strongly believe that the most effective research and studies out there are those in which the researcher has a personal stake in the matter. While effective research can certainly be conducted without such an attachment, there is fundamentally always a difference when the researcher is personally invested. At the same time, I understand that it is equally as important to maintain a sense of professionalism; yet, with skill, both the professional and political can be balanced. As is often said, the personal is political and, by extension, also professional, in my view.

Originally, I had a vague idea for my master’s thesis that involved exploring the experiences of women with chronic mental illness. My interest in the topic stems from a variety of identities. First and foremost, I identify as a woman. Having attended an American women’s liberal arts post-secondary institution for my Bachelor’s degree in psychology, I was exposed to a great deal of feminist ideology and rhetoric. The institution helped shaped my interests and strengths as a woman. I became keenly interested in advocacy for women’s mental health rights and experiences. My aspiration to dive into research that could have a potentially groundbreaking impact on the livelihoods of women was prime fodder behind the origins of this research.

Secondly, I have my own experiences with chronic mental health issues. At the age of 17, I was diagnosed with major depressive disorder and generalized anxiety disorder. At 21, I was diagnosed with an eating disorder NOS (Not Otherwise Specified). While I received these diagnoses at a relatively young age, I am acutely aware of the fact that I had struggled long before the formal assessments were initiated. The road has been long and to this day, I continue to wrestle with the impacts of my mental health. In fact, conducting the research at hand and

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writing this paper has proven a test of my mental health and my abilities to look past the limitations of my own chronic mental illnesses. As such, I believe that I am well-positioned to be an empathic researcher, sensitive to the participants' stories. At the same time, I do not possess an ADHD diagnosis which potentially permits me to maintain some distance and objectivity.

Furthermore, I am a Master's-level student in Counselling Psychology at the University of Ottawa. The skills and knowledge that I have obtained throughout this educational program has assisted in honing my interests with regard to specific demographics I am interested in working with as a psychotherapist, namely women with life-long mental diagnoses. Indeed, the counselling skills that I have developed in recent years helped facilitate the interview process.

In the end, I landed on the topic of exploring the experiences of women struggling with an ADHD diagnosis after multiple discussions with my supervisor. As a diagnosis, ADHD possesses an overwhelming male connotation, both in the clinical and research worlds in addition to the world of the general public. Combined with my passion for women's mental health, the proposed topic formed the ideal amalgamation of my interests with potentially actionable and consequential outcomes.

CHAPTER FOUR

Results

In this chapter, I present and discuss the results that arose from the thematic analysis that was conducted, as outlined in the previous chapter. First, I present the 4 emergent themes from the data, accompanied by a table that illustrates the themes in relation to the subthemes that were also identified. The aim of the identification of themes and subthemes is to hopefully address the phenomena put into question by the research topic. Following the presentation of the table, I delve into further detail regarding each theme and corresponding subthemes.

Themes

Following the thematic analysis, 4 themes emerged from the data: 1) Negotiating and navigating education; 2) Experiences of mental health; 3) Socioemotional implications of having ADHD; and 4) Strategies used to cope with ADHD. Within these 4 dominant themes, 11 subthemes were identified which simultaneously serve to underscore and highlight in more detail the content of the above 4 main themes (see Table 2). The following pages will describe each theme and sub-themes in greater detail.

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Table 2*Themes and Sub-Themes Resulting from Thematic Analysis*

Themes	Subthemes
Negotiating and navigating education	<ul style="list-style-type: none"> • The adaptation of educational approaches • Experiences of academic exceptionality
Experiences of mental health	<ul style="list-style-type: none"> • Existence of diagnostic comorbidity • Evidence for the role of external validation • Internalized pharmacotherapeutic stigmatization
Socioemotional implications of having ADHD	<ul style="list-style-type: none"> • Navigating interpersonal relationships • The existence of an ADHD gender difference • The existence and reality of Rejection Sensitive Dysphoria (RSD)
Strategies used to cope with ADHD symptoms	<ul style="list-style-type: none"> • The value of an understanding support network • The need for daily implementation of adaptive practices • Being a self-advocate

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Theme 1: Negotiating and navigating education

This theme describes the ways in which women who have been diagnosed with ADHD have required special accommodations or adaptations in educational contexts throughout life. In this sense, they have been required to negotiate, on their own, different approaches to learning and learning how to exist within pre-existing educational systems that are not always suitable for individuals with ADHD, let alone girls and women with ADHD. Negotiating a personalized education and navigating these systems has persisted for these women since early childhood educational experiences through to post-secondary. Among the factors contributing to specialized educational needs and experiences with these women diagnosed with ADHD are: 1) The adaptation of educational approaches; and 2) Experiences of academic exceptionalism.

The adaptation of educational approaches

This sub-theme speaks to how people with ADHD, and particularly women, required, at some point in their educational careers, educational institutions to provide accommodations and changes to help them succeed academically. Typically, educational institutions and their associated approaches to teaching and learning are not set up to accommodate for a variety of unique differences among students. Generally, according to participant interviews, the long-term academic success of women with ADHD is contingent on educational approaches being adapted. In fact, many participants disclosed that early experiences in academic settings were being held back in grade school. Eliza shared, “I had a hell of a time, and I’ve repeated grade five, mind you along with another five girls,” and Alma voiced something similar: “I think I started kindergarten when I was almost six, instead of almost five.” More specifically, this is what Yvonne had to say about her experience:

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...it was basically because of ADHD...they thought I would benefit from another year of structured playing before going into the more formal setting of kindergarten, and so I got a lot of mileage out of that. I got held back in preschool.

Other early experiences in grade school are marked by relatively negative ones, as it was expressed by participants that many teachers and administrators did not know how to respond to their symptoms of ADHD (whether already diagnosed or not). Eliza captures this in a matter-of-fact description regarding interactions with a teacher in first grade:

School was hard. I was behind... I recall one thing in grade one... I go to school and the teacher wants to see if I can read... and I missed words. And then the teacher took the book away from me and said, "You can't read," so I've got some interesting tales of survival in school.

What Eliza is highlighting above is the lack of understanding some educators may have when it comes to differences in learning needs. Other parts of her interview highlight negative interactions with educators: "When I was in grade three, my teacher told my parents that I was dumb."

As unfortunate and detrimental as some of the interactions were, the participants described adaptations to their education that made the academic road ahead of them much more bearable. Cora specifically mentions taking advantage of office hours in university. Yvonne spoke more directly about adapting the system to work within her needs and constraints:

I tailored everything as quickly as I could. I ditched the maths and sciences and went full on humanities, social sciences... So when I think about it myself, why I had challenges in school and undergrad... [I] found ways to work around it... like the external structure of school, like I made it work for me. I could succeed within that system.

Eliza took a similar approach in adapting the system to her needs as well, stating, "The Dean of [Physical Education] told me you had to have math, so I said toodles." In this statement, Eliza highlights how she altered her academic trajectory to fit within subjects that she knew she

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was able to succeed in and ultimately chose a path where subjects that were a struggle for her were not necessitated.

It should also be noted that a lot of these experiences were self-driven, at once because of and despite educators interacting with this study's participants sometimes held beliefs or prejudices about their ability to succeed. Eliza speaks to this in the following excerpt:

I did a test in grade 10 for career testing, like you probably took in grade 10 or whatever. I don't know if it was called career then but we took a test, it was sent to Vancouver, to the computer so it came back and it said that ... that I should not look at getting a degree, I should go for a two year diploma and actually, my career counsellor called me in to talk about it and I said, "That's the biggest [expletive]."

Eliza's anecdote shines a light on the experience that many girls and women face in educational contexts, whether or not they actually have ADHD. Certainly, prejudices and biases against girls and women in educational contexts exist and, as exemplified in the excerpts above, these issues are frequently compounded by symptoms of ADHD. Clearly, the theme of negotiating and adapting educational experiences themselves were primarily self-driven or self-guided by necessity, as schools seemingly lacked the resources, knowledge, and/or experience to adequately accommodate the needs of girls and women with ADHD.

However, in spite of these challenges and perhaps even because of these challenges within education systems, participants also detailed experiences of relative academic exceptionalism where, overall, they rose above their peers as it related to the academic standard. In the next section, I will discuss this in greater detail.

Experiences of academic exceptionalism

Somewhat surprisingly, particularly considering that ADHD can sometimes be considered adjacent to learning disabilities (LDs) as LDs are typically comorbid with such a diagnosis (Learning Disabilities Association of Ontario, n.d.), all participants described

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experiencing academic exceptionalism in themselves throughout their education. That is not to say that participants did not describe struggles with certain subjects or approaches to learning; however, it became rapidly evident in comparing notes and codes across transcripts that all participants, despite ADHD, thrived in their education. For some, such as Alma who was placed in a gifted school after skipping grade three, their giftedness in academics was noticed and rewarded at an early age. In fact, Alma posited the existence of a phenomenon among those struggling with ADHD called “twice-exceptional”:

I’ve heard that there’s a very strong correlation of people that are identified as being high performing in terms of intelligence, or being gifted, and then also having some sort of neurodivergence along with that. I think it’s called twice exceptional. It seems like the two occur very commonly, like ADHD and gifted, or autistic and gifted, or dyslexic and gifted.

While this study in particular did not measure each participant for their respective intelligence quotient (IQ), it is clear that each participant all demonstrated the aptitude to pursue post-secondary studies at a rigorous level. I acknowledge that attending university does not necessarily imply a causal relationship with IQ, and yet at the same time the struggles of living with ADHD can be so marked that having a successful post-secondary experience is also meaningful in this study’s context.

Of particular interest is Eliza’s described experiences with grade school versus post-secondary school. As mentioned previously, Eliza did not have positive experiences with teachers who would verbally express that she did not have the aptitude to succeed in certain subject or subjects. Eliza also shared that she had a “hell of a time [in school], and repeated grade five, mind you along with another five girls”. In spite of the beliefs held by many educational professionals, Eliza went on to achieve both a bachelor’s degree and diploma at a renowned university. Regarding her academic success, Eliza said, “Most of my marks with A minuses or B

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pluses, so I really enjoyed it at [university].” When referring to the experiences of other participants, at the time of the interviews, all possessed at minimum a bachelor’s degree with at least one having a master’s degree. Not only did they pursue these university degrees, but also maintained objectively good marks – although not without incurring some sort of cost, with multiple participants expressing that while they succeeded academically, they remained miserable.

The misery experienced could potentially be attributed to each participants’ unique ability to simultaneously mask symptoms of ADHD and adapt to the educational system through coping skills. Alma addressed this explicitly in her interview, saying:

I had been living with [ADHD] for long enough at that point that I had developed a mostly functional set of masking and coping mechanisms that ... from a one-hour doctor’s interview might be hard to see or consider or understand.

Or, more simply put in Cora’s words, “I knew how to do school really well.”

Theme 2: Experiences of mental health

This theme captures several participants’ disclosures regarding their own narratives of mental wellness and illness deemed tangential to their more specific experiences living with an ADHD diagnosis. All participants felt the importance of speaking to wholistic mental health experiences throughout the interviews. With this in mind, the following subthemes resulted: 1) Existence of diagnostic comorbidity; 2) Evidence for the role of external validation; and 3) Internalized pharmacotherapeutic stigmatization.

Existence of diagnostic comorbidity

While the focus of the study was to explore the phenomenon of women living with ADHD, all participants alluded to or explicitly stated that they held other diagnoses in addition to the one central to the research. For example, Yvonne shared that in addition to ADHD, the

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psychologist provided her with a diagnosis of dysthymia, which is also known as persistent depressive disorder. Alma also spoke openly of her experience with obsessive-compulsive disorder (OCD) and both Eliza and Cora were transparent about having major depressive disorder (MDD).

On one hand, for Yvonne, there were some questions regarding a possible linkage between her ADHD diagnosis and dysthymia diagnosis:

I've never fully explored [the dysthymia diagnosis], and plus I don't know if it's really truly tied to my ADHD diagnosis or if it's tied more strongly to [how I was raised]. I think there's an element of depression that comes with [having ADHD], just because the struggle of not understanding a calculus concept [for example], you realize, what is my self-worth?

In some respects, Yvonne has not delved deeper into the potential connection with ADHD and depressive symptoms, and yet she does recognize that some of the challenges of ADHD could predispose an individual to feelings of low self-esteem which can, in turn, lead to depression or dysthymia. It should be noted that for Yvonne, in particular, she was diagnosed with ADHD later in life and therefore was not able to mitigate pertinent challenges early on life.

On the other hand, Alma is quite clear in believing that her struggles with mental health, as they pertain to depression, anxiety, and her OCD diagnosis, are the result of ADHD symptoms. More specifically, Alma addresses the relationship between ADHD and emotional regulation:

[Sometimes], for a minute, I'm thinking, 'Oh my God, everyone hates me.' I mean, having anxiety on top of [ADHD] makes it harder... 'cause your brain convinces you even more that [the thoughts] are true. So I'll deal with that sometimes, and that's also [an issue] that's been difficult socially in friendships and my whole life, but it's hard because I forget that ADHD is also tied to emotional regulation, so I get a lot of times where I'm like, God, why do I feel like this? And then twenty minutes later I'll be all right.

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Emotional regulation is a key part of success in life, particularly social success, and failing to regulate effectively can lead to struggles in one's social life and otherwise. As Alma aptly points out, emotional regulation can be one challenge for individuals with an ADHD diagnosis and can also be tied to other mental health disorders. As such, emotional dysregulation as a symptom can be attributed to a vast array of diagnoses or predispose an individual for developing a comorbidity. As evidenced above, comorbidity of disorders can complicate an individual's experience in managing one diagnosis over another. Since experiences of mental health vary on a case-by-case basis, if a professional does not direct the person to the appropriate supports and address the predominant mental health disorder, individuals could find themselves in a potentially dangerous or harmful situation.

Evidence for the role of external validation

As alluded to previously, ADHD can impact a person in many different ways. Because a person's experience is unique and variable even within the diagnosis, these affected individuals are largely responsible for a lot of their own care and positive progress. A common trend quickly emerged between participants' interviews where they spoke to moments where they felt validated by others in their experiences (*external validation*). It seems that external validation is an important factor among the women interviewed in promising positive mental health, encouraging oneself, and boosting self-esteem.

Alma has been able to use certain opportunities to her advantage, intentionally or not. For example, she once worked at a camp with a large population of young kids with ADHD. She says:

I ended up actually helping a lot of little kids with ADHD work their through [disagreements] with another kid or an emotional meltdown or something, and that was really fulfilling work... In terms of getting more comfortable being public about my ADHD and kind of seeing the good in it, it was really beneficial.

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The external validation that can support positive mental health in people with ADHD, specifically women who may not be as open about their diagnosis, does not necessarily have to be spoken but as described above, can be embedded in an experience – such as working as a camp counsellor. In some ways, external validation can not only help with feeling better about oneself but also provides a unique opportunity for self-reflection and enlightenment.

When I've run girls' groups... and if kids were depressed, I can say, 'You know, I can relate, it's okay... We've sat down and I said, 'I get what you're going through, but you're a little different than I am, and so this is why you're on meds to help you out.' And it's not really until this year, or even last year that I started thinking about [my ADHD], when I started dealing with little ones that had ADHD.

Cora is exposed to a lot of young people in her profession who also struggle with the same or a similar diagnosis. In some ways, being in an environment with people who are similar, or who remind oneself of childhood experiences, provides external validation for why things in the past (or present, for that matter) occurred the way that they did. Not only is Cora able to gain further insight about herself by working with children with ADHD, but she is also given the opportunity to reflect on her past as an undiagnosed youth.

Internalized pharmacotherapeutic stigmatization

Interestingly enough, while participants were eager to speak about their experiences as women living with ADHD, there was considerable mention of or allusion towards a hesitancy in taking psychotropic medications to treat symptoms of the mental disorder in question. For some, this meant remaining absolutely unmedicated while, for others, this meant medicating on a case-by-case basis if they were anticipating additional stress, et cetera. The approaches to pharmacotherapeutic treatment have also varied over time, which is particularly evident in the following passage spoken by Yvonne.

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I was medicated [as a child]. I'm not sure for how long, but it wasn't very long. [My parents] were just seeing the start of the ADHD diagnosis craze and the vast over-prescription of Ritalin, and so they were kind of like, 'We don't want that.'

In Yvonne's case, the resistance to medication began at an early age and was influenced by her parents and society at the time. It was not until Yvonne was a young adult, when a long-term romantic relationship was breaking down, did she try medication again:

I went to seek treatment in my early twenties [around the time of the relationship breakdown]. That's when the diagnosis of major depressive disorder got added to the ADHD. So, I went into treatment with a psychologist. I think a prescribing psychologist or maybe she was a psychiatrist, but I started on Ritalin, and then over the next three years, I was on a couple of different anti-depressants and Ritalin.

In some ways, Yvonne's change of heart with regards to ADHD medication was informed by her age and ability to make informed decisions for herself. Yet, the decision was precipitated by a stressful situation, begging the question of whether the stressful situation only further exacerbated the more negative symptoms associated with having ADHD.

[Regarding medication,] it has been very, very low touch for the past eight years where I just kept pulling up the same report for every new doctor that I've gone to. It's like, 'Hey, by the way, I need a script for this.' ... Now I'm [taking] generic Ritalin... which I rarely take because it does mess up with my clear thinking and it just clarified all of the other struggles that I have... My dose is currently still quite low. And I only take it as needed because I've since started my own side business [in art], so that creative side to me is fairly important that I not touch or not affect. My current dosage is still five milligrams, and I think that's better for me because if I need just to take the edge off, I'll take half a pill which is two-point-whatever, depending on the cut, and if I need something additional then I'll just take two, and that will be ten [milligrams]. Because I so seldomly take it, my body has not developed a resistance to it. I left one job because it freaked me out that my dosage increased from five to fifteen [milligrams]. It might not be a lot to some, because I think some people started as a child and they [take] sixty [milligrams], but for me, the fact that it tripled meant that I probably was in the wrong industry.

Eliza speaks to an innate fear and worry that the medication will dampen her personality and strengths, seemingly attributing them largely to the ADHD. As such, Eliza has opted for what she aptly describes as a "low-touch" approach to her medication where she self-medicates on an as-needed basis. In some ways, Eliza alludes to an internalized bias against medication that

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might mute her as a person and go against her values of creativity and innovation. In some ways, it is Alma who succinctly describes the reason for medication non-compliance or hesitancy:

“Taking a medication that is a controlled substance is really difficult.”

Theme 3: Socioemotional implications of having ADHD

This theme speaks to the various interpersonal and intrapersonal experiences and consequences that participants described as it related to their diagnosis of ADHD. Essentially, an ADHD diagnosis as a woman affects, to some degree, the socioemotional elements of a lived experience. This theme includes the following subthemes: 1) Navigating interpersonal relationships; 2) The existence of an ADHD gender difference; and 3) The existence and reality of Rejection Sensitive Dysphoria (RSD).

Navigating interpersonal relationships

Learning to navigate the world through the lens of ADHD is not without its challenges, and this is something that all participants attested to during their interviews. A lot of the time, it can be difficult to even discern the challenges, which Alma addresses below.

You look at my social life and my academic life, [and] it could look very much like, ‘Oh, this girl’s functioning, she’s fine. I don’t see an issue here,’ and it’s hard to explain... the lived reality and the daily experience of it.

For the most part, the social challenges appear to have been most evident in the early years.

I struggled socially because I was kind of awkward and impulsive, and there were factors that kind of set me apart from my classmates and made me a little bit weird.

Yvonne notes that her differences – primarily those symptomatic of her ADHD – made it difficult for her to form friendships during a key socio-developmental period of life. She goes on to describe the approach used to rectify any issues she might have had when it came to relating to her peers.

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I was fully integrated into regular school, and the narrative at that point was that I had ADHD when I was younger, and then I grew out of it. That was the message I got from my parents... They made sure I got the support that I needed as a child, but it was very much like, 'This is a challenge to be overcome and that it's over.'

What Yvonne captures above is perhaps more assimilation than adaptation. There is a sense that for girls and women, in whom interpersonal relationships are seen as a natural strength and affinity, the consequences of an ADHD diagnosis must be overcome to better fit in, masking one's ability to successfully navigate social settings. However, for others such as Alma, excuses were made to explain away resultant ADHD differences:

I grew up having a lot of my own brain weirdness explained to me by my mother like, 'Oh, well, it's just because you're smart. That's just what it's like being smart.' It never quite sat right with me, because I would be friends with kids at school and my mother would be like, 'Well, maybe you don't get along with them because they aren't smart like you.'

In this sense, Alma was encouraged to relate to others in a hierarchical manner, but she obviously wanted to push back against this idea ("...it never quite sat right with me..."). Nevertheless, it is apparent that Alma struggled to form positive relationships with other peers and that some of the adults, including her mother, attributed this struggle to symptoms of her disorder.

Often, it was the relationship with a significant other that highlighted the more salient interpersonal challenges faced by the participants. Yvonne's first relationship resulted in divorce, due to a variety of issues, with one being an inability to acknowledge her ADHD diagnosis at the time. Alma is up-front and admits that her communication skills can be lacking, as she can be forgetful when it comes to informing her partner about important things. Cora, in particular, was quick to admit that she "tired out" her husband because she feels a need to keep herself busy and stimulated.

He says, 'You always have to do something,' and that's true, even at home... There are some times when... it comes out like I'm nagging and sometimes I'm not understood.

It is clear that the manifestation of ADHD symptoms has the potential to cause tension or friction in interpersonal relationships, due to a lack of understanding or something else, and most

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definitely in shared spaces, such as with a life partner. However, it is not impossible, as evidenced by all four women maintaining healthy and successful social relationships at the time of their interviews.

The existence of an ADHD gender difference

It goes without saying that the experience of ADHD is simultaneously generalized among its diagnosed population and yet also unique, specifically within the female demographic. While there were no questions specifically targeting the gender difference, the study was framed in a gendered way and some women participants brought it up themselves.

With ADHD, [there] really is a difference between boys and girl. Because girls, I think, go unnoticed.

Cora's unique point is twofold: first, girls are unnoticed in society in general, as was described earlier on during the review of the literature. However, secondly, ADHD should not and cannot be measured or assessed the same way for males and females, as females with ADHD express symptoms differently. In other words, their symptoms are unnoticed. Alma succinctly addressed the main reason why:

...it's hard to diagnose girls with ADHD and teenage girls because when you have something where the DSM [Diagnostic and Statistical Manual] criteria are based on observations in a nonrepresentative sample group [males], you're going to get nonrepresentative answers for your criteria.

The existence and reality of Rejection Sensitive Dysphoria (RSD)

Arguably one of the most astounding discoveries to result from the interviews with the women participants was acknowledgement of a phenomenon unique to ADHD. This phenomenon is often referred to as Rejection Sensitive Dysphoria (RSD) and was initially raised in interview by Alma.

I would say the biggest challenge my ADHD gives me overall is probably the symptom that screws me over the worst... the emotional side of it... that's a part of that I think a lot

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of people overlook or don't talk about, and it's probably the thing I wish people understood about ADHD the most. And I see it a lot, especially in ADHD women... I think I've seen it called rejection sensitive dysphoria in place. [Basically], rightly or wrongly, when I perceive that someone is upset at me or annoyed with me or disappointed in me, it feels like there is a black hole in me. It feels horrible, and it is crushing, and it is the only thing I can focus on, and in general, I feel emotions very, very intensely. They come over me like the dial is all the way to eleven. And it can be challenging sometimes, just feeling something that strongly, the good news is that [the feelings] don't last.

While other participants did not name the phenomenon directly, they indeed identified patterns or trends that accurately aligned with the presentation of RSD.

I yearn for acceptance, and I don't get that acceptance, my mental health just goes down.

Underscoring the meaning of the words *rejection* and *sensitive* which comprise the phenomenon at hand, it can be deduced that when Eliza is not feeling accepted – in other words, is feeling rejected – she is acutely affected in a negative way, both emotionally and mentally. She's not alone, and Yvonne provides some concrete examples of experiences that could easily be tied to exhibition of RSD.

My reactions were exaggerated beyond what other people's expectations were... When I was a [child], when I would get really frustrated or upset, when I would mess up in some way, like I couldn't tolerate that shame and I would just freak out... It's gotten better, but I still have a pretty low tolerance for strong, negative emotions.

It is the case that natural maturity development can moderate for the negative outbursts associated with RSD, yet that does not diminish the very real experience that women with ADHD continue to have as it relates to such strong, uncomfortable feelings. Alma expressed her concern about the phenomenon and her eagerness to have it directly addressed in the future.

... I've heard this a lot from other people with ADHD... We wish this was more studied and more widely understood, and that people kind of understood that our emotions can be all-consuming and turn on a dime, and it doesn't mean we don't care or that we weren't actually upset in the first place, [but] that our brain just decided we were done. It's like speed-run emotion.

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It is easy for practitioners to assume ADHD only manifests in school or work settings, that the child is ‘hyperactive’ and needs to run off some energy. However, such a limited perspective does not acknowledge that ADHD is also an emotional disorder, associated with other disorders like depression or anxiety. Even presently, practitioners may fail to consider emotional lability as a criterion when assessing females for ADHD.

Theme 4: Individual strategies used to cope with ADHD symptoms

This theme encapsulated the commonly used strategies and coping mechanisms that participants described as being effective in moderating or accommodating their symptoms of ADHD. Participants described a wide variety of strategies, resulting in the emergence of 3 sub-themes: 1) The value of an understanding support network; 2) The need for daily implementation of adaptive practices; and 3) Being a self-advocate.

The value of an understanding support network

Above all, participants spoke to the necessity of a strong social network to help them navigate challenges in life. As mentioned in a previous subtheme, navigating interpersonal relationships with others did not always come easily. Thus, once connections were made, these bonds developed into highly valued friendships that not only existed to satisfy a natural human need for socialization, but the additional need to feel heard and understood in the context of each participant’s diagnosis. Cora speaks to this directly:

Regarding my friends, they’ve just gotten used to me... It took time [for them] to get used to me and I’m happy that they did because I found a pretty good set of friends in my network.

For Cora in particular, her support network provides support in that they are able to accommodate what Cora calls her “need for stimulation”:

...Because I have various networks of friends from different school systems, different countries, I’m able to tap into them as needed. So, if one network does not provide the

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stimulation and satisfaction I crave, I reach out to a second network or third... Because they've known me for such a long time, [they understand] something random, out of the blue [from me]. So, I'm happy I've gotten to that place and I'm able to lean on them for the stimulation I need.

What is especially unique about Cora's support network is that it disrupts the more commonly held view that support networks are there for people when faced with difficult circumstances. Arguably, an effective and wholistic instrumentalization of a support network would make use of all its aspects, including the ability to decrease the negative side effects of an individual's symptoms – such as the need for additional stimulation, such can be the case with people with ADHD. Cora is not alone in this, as Eliza includes the way she was raised as being valuable and instrumental in her growth:

[My] parents spent a lot of time with us, my brother and I... Growing up was really busy, like we were skiing, we were water skiing, we were camping. Really supportive on both sides of the family.

It appears that both Cora and Eliza feel wholly embraced by their social circle as it relates to presentation of their symptoms and this is a strong element of support for the two of them. Somewhat tangentially, both Eliza and Yvonne echo that that they are able to speak openly with their support network when the symptoms of ADHD might be particularly challenging on any given day. In this way, however, they are addressing their diagnoses directly with their support networks, setting them apart from Cora's interactions with her support network, which centre more around acceptance of the outcomes of symptom flare-ups. For example, Yvonne stated:

My partner, my parents, as well as my friends [are supportive]. I'm very open about my diagnosis and people know. And I'll mention it if it comes up, if it's relevant, and I'll just be like, 'Yeah, yeah, it's great to see you. ADHD is kicking my ass today, what are we talking about?'

What Yvonne is highlighting here is her comfort level with being upfront about her quotidian experiences with her diagnosis, which simultaneously assists her network in being able

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to better support going forward. Eliza describes something similar among her immediate family, which she identifies as forming her current supports:

[My husband] was really supportive, and my family and stuff... and my best friend, too, down the street. She kicked my ass one day, so [getting me to go] for a walk and [telling] me to get my [stuff] together and I did.

Evidently, there exists a common thread among participants of transparency and authenticity in how they relate to their support networks in order to better manage their diagnosis of ADHD. Cora is authentic in her need for stimulation through her networks and Yvonne is transparent and authentic by being vulnerable when she is experiencing an especially tough day. Alma take this a step further and highlights the reciprocal nature that can be sometimes adopted by support networks:

I think there's some kind of camaraderie and it's not like I'm seeking it out, but it's funny how a lot of the time I'll make friends with someone and they'll tell me two months into us being friends [that they have ADHD] and I'm like, 'Oh, you too?'... Other sources of support would be my partner, my friends, having a lot of friends who have ADHD... It just happened by accident, but it helps a lot because if I'm feeling really frustrated about my brain, I have like eight people I can talk to and they'll be like, 'Dude, me too. It's the worst.'

In some ways, it appears Alma has serendipitously been drawn to individuals who happen to also possess an ADHD diagnosis. Clearly, Alma has also opted to continue to include these individuals among her close friends who, by virtue of their own experiences, are in a position to provide the necessary validation and supportive ear that Alma is seeking out in certain instances. In fact, this is something that Cora touches on later, too:

I do have friends that are in similar situations as [I am]... So we discuss ways to get through the day, or if I'm having trouble at work, a lot of my college friends, because we're at the same age, we're at the same stage in our professional career [and] they're able to give me some tips that work for them.

Cora is reflecting what Alma has described as it relates to the purpose of her support network, which is element of finding commonality with others which, in turn, normalizes or, at

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the very least, de-pathologizes the individual experience with ADHD. Furthermore, Cora speaks the value that networks may have as it relates to the working world, which I will discuss later on.

Ultimately, while the nature, use, and make-up of support networks might differ widely among each participant, an important takeaway from this particular subtheme is that support networks are instrumental to the health and well-being of each woman, satisfying differing needs in a variety of ways, from directly addressing needs borne by ADHD symptoms to peer helping relationships to ideas about potential skills to make life easier.

The need for daily implementation of adaptive practices

Throughout all four interviews, it became increasingly apparent that structure has been scaffolded into each participant's life simultaneously at various stages in their life, in various ways to help them adapt. All four women spoke about ways they have implemented tools to make their lives easier while managing symptoms at the same time. Specifically, Eliza utilizes strategies that simultaneously satisfy her need for stimulation while at the same time reigning it in to achieve goals in her personal and professional life. In this first passage, Eliza speaks directly to a technique that helps her focus her mind on a task:

People with ADHD, we always seek stimulation, whether it would be from music, hearing, food or exercise, whatever. And in order to get on with your life, you need that constant stimulation to fulfill that bucket that you have. And that for me is chewing gum... I'm always listening to music, drinking coffee, and I go through a pack of gum, maybe one and a half [packs]... I go through one and a half every week or so, because the stimulation of my jaw moving keeps me focused on whatever my mind is doing.

In addition to gum-chewing, Eliza also relies on other concrete strategies that aid her in accomplishing goals or meeting deadlines:

Google Calendar is one thing that I like to use, [and] started to use more. [Also] just writing more confirmation stuff, such as a text, like, 'Hey, confirming that we're meeting... Still going to brunch tomorrow?'

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All the women interviewed spoke openly about struggling with inattention, a common ADHD symptom. Because of this, it can sometimes be difficult for them to keep track of everything they need to do in a given day, be it related to daily executive functioning or meeting deadlines for assignments at work. For others, Yvonne in particular, “just doing it when I think of it” is the strategy.

Instead of planning to go to the grocery store and get [the item], which I will then forget to do, I just literally take out the phone and buy it right then. [Also] to-do-lists prioritized on my phone, automatic payments, online shopping, when I think of it.

It is clear that, for most of them, including both Eliza and Yvonne above, list-making of some sort has proven to be essential to their holistic success.

I think the organizational system that’s worked best for me in home, school and work and life is I am a list maker. I have a notes app on my phone, and the day I figured out that my phone could be my ADHD coping tool, it just changed my life. I could keep track of it [because my phone] is always on me. I’ve tried to use planners but it was always, like, I lost my planner somewhere.

I make a list for the next day before I got to bed each night – it’s like the last thing I do – I make my list and set my alarms and I have trained myself to the point where I can’t go to bed without making my list... It’s embarrassing, I put literally everything that needs to be done the next day, down to getting dressed.

Above, Alma provides a detailed description of how extensive her to-do lists are.

Subsequently, Alma is also speaking to how ADHD is more than just focus or attentional issues, but that it can have repercussions for day-to-day duties, as she curates her lists to include menial tasks, such as getting dressed or brushing teeth. When a person’s executive functioning is limited, as in the case of someone with ADHD, the impacts on a person’s mental health can be detrimental and costly. Alma’s strategies help counter these potentially negative consequences:

There’s a very simple euphoria of just crossing off something that I do every day as part of my routine anyway. It makes me feel like I’m accomplishing something. And it helps with the executive dysfunction.

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There can be an inherent sense of achievement from crossing off items on a to-do list, no matter how small, and this can often encourage increased motivation. Success, ultimately, seems to hinge on the self.

Being a self-advocate

Each woman interviewed for this study spoke on a variety of topics and touched on crucially important issues. However, one strong, salient theme throughout was the personal strength of each participant, captured through the narrative they shared. Because ADHD is a gendered diagnosis, leading to a variety of misunderstandings and biases towards girls and women with the disorder, the participants spoke to the necessity of having to advocate for themselves in a variety of contexts. First, it begins with acknowledging the issue.

I was struggling. I had a great job, good apartment with my partner, but I was still just really struggling... I was like, 'Oh okay. Maybe I should stop with this denial thing and admit that I have a problem and get help.'

Yvonne goes on to address how she stands up for herself and her medical needs as it relates to medication, which is her favoured treatment for ADHD:

I would encounter a lot of my contemporaries who [would say], 'I just don't want to be dependent on a chemical.' I just have no form of patience for that. Give me the drug. It works and just look at my CV and try and tell me that being dependent on the pill has stopped me from doing anything.

The theme of not letting one's diagnosis get in the way of success seems to echo across participants' narratives. Cora was diagnosed much later in life, which initially resulted in requiring some time away from work. After accessing resources for support, Cora was ready to go back to work. However, she did not anticipate that her employer would be so reticent.

I was quite strong by then... I went back to work. The head of Human Resources said, 'We could put you part time,' and I said, 'Screw you, I'm ready to go, [to work full time].'

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For Cora, this resulted in a shift in the way she engaged with the clients in her workplace and a shift in mindset for how she prefers to live her life nowadays.

I tell that to [clients], this is what I believe. Don't let anyone squash your dreams. It might take you longer, you might have to adapt things, but to get my degree was great and then on top of that, I got a graduate diploma.

PART FIVE

Discussion

This study aimed to provide an exploration into an important question, namely that of the lived experiences of women who have been diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD), especially considering the fact that the existing literature on ADHD among women has been significantly overlooked over the years. Women's experiences of ADHD within the contexts of healthcare, education, and their personal lives were examined through a thematic analysis approach, inspired by grounded theory, in order to gain a better understanding of personal challenges, successes, and strategies used. The coding process resulted in four distinct themes, with eleven subthemes organized within these. The results demonstrated that women with ADHD face challenges in a wide variety of contexts, such as education, and some of these challenges pertain to their mental wellbeing or the socioemotional. It became rapidly evident that due to their unique experiences of being women with a male-typified diagnosis, these women often have to take on the role of self-advocacy so they can access the supports they may need and speak up for greater understanding by others.

In this chapter, the four main themes that came to fruition, as a result of the analysis, will be discussed in greater detail with reference to existing literature and research. The discussion will also reference the importance of these thematic discoveries to the field of counselling psychology and, to a much larger extent, the women demographic navigating life with ADHD. In conclusion, limitations pertaining to the research at hand will be presented in addition to implications at-large and recommendations for future research directions.

Discussion of Results

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The four main themes presented in the previous chapter were 1) Negotiating and navigating education, 2) Experiences of mental health, 3) Socioemotional implications of having ADHD, and 4) Strategies used to cope with symptoms of ADHD. The following discussion of results will be organized in this structure, with the corresponding sub-themes, and findings will be situated within the literature while also acknowledging moments where either connections can be drawn or add to the current body of research within the field of female ADHD.

Negotiating and navigating education

This theme speaks specifically to the fact that women's experiences with the education system, in the context of their ADHD, was neither straightforward nor facile. The language used, namely 'negotiating' and 'navigating', imply the relatively labyrinthine process that participants expressed having to navigate in order to receive the supports and understanding necessary for them to succeed academically. In fact, it appears that the labyrinthine nature of these women's experiences in education is due to their presenting issue of ADHD, and the problem is further compounded by a female gender bias. According to a review done by Brzezinska et al. (2021), teachers are less likely to notice symptoms of ADHD in girls since the diagnosis is largely associated with boys. Therefore, it can be inferred that referrals for girls for additional support, or even a psychoeducational assessment, are less likely to occur in both the early school years and key developmental periods in childhood. As such, one sub-theme related to this issue arose, namely *the adaptation of educational approaches*.

Adaptation of educational approaches. Educators are faced with a variety of challenges and demands when students with ADHD are placed in their classroom. For girls, adaptations in education may be harder to come by as educators tend to be looking more to the boys in the class for symptoms of ADHD (Brzezinska et al., 2021). Other educators are, somewhat ironically

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perhaps, uneducated with regards to the ADHD and the effects the disorder can have on student academic performance. This was the unfortunate case for Eliza during grade school, when a teacher expressed a lack of confidence in Eliza's academic aptitude, referring to her as "dumb" in a conversation with her parents. Without adequate training on ADHD in the classroom, teachers may develop negative perceptions about students with the disorder which, in turn, can influence how the teacher grades the student (Kendall, 2016).

Studies have identified that, due to the male referral bias for an ADHD diagnosis, girls in the classroom tend to have less structural support to help them with their learning (Deane & Young, 2014). Considering this, girls often come up with their solutions to support their own learning, which can sometimes be maladaptive (Deane & Young, 2014). For this study's participants, all of them spoke of having to make adaptations themselves, specifically Yvonne who mentioned learning how to make the education system work for her. Not unsurprisingly, all participants spoke of having to advocate for themselves in order to have their educational experience adapted. Not one participant spoke explicitly of having an individualized education plan or additional learning supports to supplement. In a proactive learning environment, girls with ADHD can benefit additional learning supports that are implemented in conjunction with psychosocial supports (Baric et al., 2016).

Experiences of academic exceptionality. In many ways, this sub-theme appears to be overwhelmingly contrary to existing bodies of research related to academics and people with ADHD, let alone women with ADHD. In fact, some studies have identified that women with ADHD are more likely to experience impairment as it relates to education and their academics (Fuller-Thomson et al., 2016; Fedele et al., 2012). In general, ADHD is a disorder that is often

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associated with low levels of educational attainment and significant underachievement academically (Young et al., 2020).

A number of researchers have studied the longitudinal effects an ADHD diagnosis can have on academic achievement. Scholtens et al. (2013) conducted a study whereby students (47% of which were girls) were followed over the course of middle and high school, including three checkpoints at the sixth, eleventh, and twelfth grades, respectively. Ultimately, it was concluded that early struggles (i.e., present in the sixth grade) among students with ADHD negatively impacted future academic achievement. Another study conducted in Australia suggested that students with ADHD would benefit from remedial classes in literacy and numeracy (Lawrence et al., 2021). Furthermore, a third study positioned that even with medical intervention through medication and/or counselling, students with ADHD were unable to rise above their purported academic challenges (Advokat et al., 2011). However, in the case of the study at hand, while all participants expressed some type of academic struggle (as previously detailed above), all also spoke of experiencing academic exceptionality. In other words, all participants, despite their struggles, performed well and often above average in educational settings.

Particularly, Alma brought forth the concept of twice-exceptionality, considering that she herself was identified as a gifted student and attended a school for academic high-achievers. While other participants did not explicitly discuss twice-exceptionality, they all demonstrated successful academic paths – unusual in light of the existing literature. While some certainly struggled, like Eliza who was held back in the fifth grade, all participants went on to achieve at least a university undergraduate degree.

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The concept of twice-exceptionality (“2e”), which is sometimes also incorrectly referred to as giftedness, describes an individual who is academically gifted and simultaneously holds a disability or mental disorder diagnosis (Lewis, 2021; Saldana et al., 2021). Lewis (2021) acknowledges that education and mental health systems are currently not set up to provide appropriate interventions to students who possess asynchronous intellectual, mental, and learning profiles. As such, it can be confusing for students to figure out how best to advocate for their needs to be taken seriously. Saldana et al. (2021) specifically speak to how practitioners can adapt their approach to 2e individuals, such as utilizing a strengths-based approach to counselling.

Experiences of mental health

While ADHD is a mental disorder that is frequently understood as a learning or cognitive disorder, in reality many researchers believe it better aligns as an emotional disorder (Faraone et al., 2019; Hirsch et al., 2018; Turkia et al., 2021). As such, ADHD may have wide-reaching implications on the overall mental health of an individual and can predispose someone to the development of comorbid disorders, namely because of the emotional lability that remains a core feature of the diagnosis (Breux et al., 2021). Thus, the following three sub-themes were derived from participant narratives and speak to their lived experiences of ADHD within the context of mental health: *existence of diagnostic comorbidity*, *evidence for the role of external validation*, and *internalized pharmacotherapeutic stigmatization*.

Existence of diagnostic comorbidity. According to Regan and Tubman (2020), co-occurring psychiatric disorders are more likely to appear during the individual’s adolescence and having ADHD is a biomarker for susceptibility. All participants disclosed having diagnoses of other conditions in addition to their ADHD, including dysthymia, major depressive disorder

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(MDD), anxiety, and obsessive-compulsive disorder (ODD) – all of which arose after childhood. Their experiences are strongly supported in the existing literature. Generally, girls and women with ADHD are more likely to face mental health challenges, both externalizing and internalizing (Tung et al., 2016). One study following girls with ADHD from childhood to young adulthood over a period of 11 years and deduced that this particular demographic was at higher risk for eating disorders, addiction, mood, and anxiety issues (Biederman et al., 2010). Reasons for this may be due to the fact that the behaviours of girls with ADHD fall considerably outside the norms society expects of females, which has the potential to lead to social rejection and isolation, in turn leading to the development of comorbidities (Chronis-Tuscano, 2022).

Evidence for the role of external validation. Participants spoke about moments where they felt that other people had expressed commonality of experience or validated the challenges these women face as a result of being diagnosed with ADHD. Validation by other people, or external validation, can be a way for someone to express empathy for someone and the situation they are in (Kim & Kim, 2013). While there is little research about the role validation might play in the mental well-being of women with ADHD, within the field of counselling psychology, validation can be exceptionally helpful in increasing feelings of belonging, boosting levels of self-esteem, and reducing low mood (Kim & Kim, 2013). As such, external validation moderates and alleviates feelings of isolation and rejection that women with ADHD often experience.

Internalized pharmacotherapeutic stigmatization. Medication is a common treatment for those with ADHD, regardless of gender. Stimulants and non-stimulants can be prescribed to treat the disorder, while stimulants remain the most popular for treatment (CDC, 2021). However, it should be noted that a recent study has found that non-stimulants may actually be more effective in treating females with ADHD (Kok et al., 2020).

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Some participants shared that they had taken ADHD medication in the past but acknowledged the societal views of taking a controlled substance influenced their desire to treat with prescription drugs. This speaks to how participants may have an internalized stigma, like much of the general public, towards the use of stimulant drugs, regardless of their effectiveness for ADHD treatment. Internalized pharmacotherapeutic stigmatization is not uncommon among people with ADHD. According to a study done by Gajria et al., (2014), one of the main reasons ADHD patients discontinued psychotropic medication was due to the associated social stigma. In some cases, internalization of self-stigma can lead to the aggravation of symptoms (Mueller et al., 2012).

Furthermore, parents and other immediate family members like siblings can play a role in perpetuating stigmas surrounding medical treatment of ADHD (Mueller et al., 2012). Yvonne specifically spoke of a time when she was prescribed medication but quickly discontinued, due to attitudes held by her parents. One study conducted by Ahmed et al. (2017) led focus groups of parents to explore factors that impacted ADHD treatment. What the researchers ultimately found was that parents would quickly discontinue medication for their children when side effects arose (e.g., lack of appetite and sleep loss), and cited concerns about possible future drug addiction and the stigma associated with taking stimulants.

Socioemotional implications of having ADHD

Older conceptions of ADHD tend to view the diagnosis as primarily characterized by inattention, hyperactivity, and impulsivity, yet more recent research suggests that emotional dysregulation is an important symptom that has considerable impact on the degree of severity with which an individual experiences the disorder (Rufenacht et al., 2019). Interestingly enough, a 2017 study examining the subcortical morphology in young male ADHD brains versus young

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female ADHD brains found that males were more likely to experience emotional dysregulation, due to the presence of a smaller amygdala and bilateral globus pallidus (Seymour et al., 2017). However, all participants in the study at hand referenced the socioemotional facets of their lives that they felt were coloured by their experiences with having an ADHD diagnosis. There exists little to no existing studies regarding emotional dysregulation specifically in girls and women with ADHD and while the previously mentioned study suggests that girls with ADHD are perhaps less susceptible, that does not necessarily imply that they do not experience socioemotional issues to a similar degree as boys and men. As such, the following three sub-themes were identified to provide a general idea of the challenges women with ADHD face in the socioemotional context.

Navigating interpersonal relationships. A common theme among all participants was the idea of social awkwardness and a struggle to create and maintain friendships, especially in the grade school years. This experience is not uncommon and is consistent with the literature, as one formative study by renowned ADHD researchers Drs. Ross Greene, Joseph Biederman, and Stephen Faraone found that girls with ADHD experience significant social impairment, irrespective of gender (Greene et al., 2001). Girls seemed to struggle more in the domains of ability to gauge problems in social interactions, and mediate interactions with peers, parents, and siblings.

Looking beyond childhood, struggles in interpersonal relationships persist. All participants spoke of experiencing tension in their romantic relationships, usually due to romantic partners not being able to tolerate ADHD symptoms. For some, such as Cora, the results were divorce. However, Cora and others are not alone: Babinski et al. (2011) conducted a preliminary exploration investigation of outcomes of young women with ADHD and concluded

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that this demographic tends to experience greater conflict in familial relationships and in romantic partnerships.

The existence of an ADHD gender difference. While the overarching point of this research is to highlight gender differences in ADHD, participants primarily spoke to the fact that the difference leads to a lack of understanding and a lack of representation. Participants shared that they felt their ADHD went unnoticed because of their gender and that because DSM-V criteria does not accommodate for gender differences in the criteria, the diagnostic manual does not capture diverse symptomatology well. As Quinn (2005) highlighted, girls and women with ADHD are more likely to remain hidden and fly under the radar of mental health professionals due to differing presentations of the diagnosis. A further review by Quinn and Madhoo (2014) uncovered that girls and women usually fall under the threshold to meet DSM-V criteria, as symptoms of inattentiveness tend to present more prominently than symptoms of hyperactivity and impulsivity.

The existence and reality of Rejection Sensitive Dysphoria. Alma first brought up the concept of Rejection Sensitive Dysphoria (RSD) as being a unique symptom of ADHD. Subsequently, experiences described by other participants, such as strongly desiring to be accepted in the eyes of others or having disproportionate emotional reactions, were understood to fall neatly under RSD.

According to review of RSD among people with ADHD, Bedrossian (2021) suggests that the concept has been acknowledged as an important aspect of the ADHD experience in Europe for some time, while clinicians in North America have been slower to embrace it. It is estimated that as high as 99% of adolescents and adults with ADHD face RSD as well, and it is characterized by a perception of being rejected or criticized by important figures in one's life. As

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a result, individual will experience emotional pain as they perceive that they are failures in the eyes of their loved ones. Sometimes, the external manifestation of RSD can be anxious or angry, meaning that an individual might express their feelings with, for example, a panic attack or perhaps an aggressive outburst (Bondu & Esser, 2014). Because research on the topic is relatively new, there are little to no existing studies that examine RSD specifically in relation to girls and women.

Strategies used to cope with symptoms of ADHD

As with as mental disorder, individuals are often tasked with having to manage with the quotidian feat of managing the functional impairment imposed by ADHD. Counselling services and medication can only go so far when people have to go about their lives, navigating through the home, work, and the world. Participants in this study specifically spoke to self-regulation techniques to reduce ADHD symptoms (*daily implementation of adaptive practices*), reliance on a social support network, and standing up for oneself (*being a self-advocate*). One influential study by Young (2005) evaluated 44 adults with ADHD using the Ways of Coping Scale, finding that this demographic was less likely to engage in adaptive coping skills in the face of stressful situations. Notably, people with ADHD may be more resistant to self-management or self-care strategies because of inattentiveness or other key ADHD symptoms (Bussing et al., 2015). Few studies explore self-management between genders, although one particular study taking a discursive approach suggests that the burden of self-management among girls with ADHD lies in confusing societal expectations of girls and women to toe the line between activity and passivity as it relates to their self-care (Bertilsson-Rosqvist & Arnell, 2018).

The value of an understanding support network. All four women interviewed emphasized the importance of support networks that were understanding and patient. Some

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participants, like Eliza and Yvonne, spoke about the freedom to be transparent with their friends and loved ones, without fear of being criticized or rejected. This is consistent with the literature as there is evidence that positive social support networks are correlated with positive mental health, and especially among women (Harandi et al., 2017). In fact, positive social support is likely to decrease the detrimental effects associated with mental health stress and increase overall life satisfaction (Harandi et al., 2017; Hennig et al., 2017). Social connections are also key in reducing symptoms of depression among girls and women with ADHD (Nilsen et al., 2013).

The need for daily implementation of adaptive practices. All participants spoke of unique, personalized ways that they have been able to self-manage ADHD symptoms. For some, that included gum-chewing for stimulation, or list-making to address challenges with remaining organized, or online shopping to address forgetfulness. While seemingly mundane, these adaptive practices help these women go about their daily lives. There is little in the literature that attests to or explores the value of mundane self-management strategies, and it appears that most researchers are looking at the big picture: psychosocial interventions or the maladaptive strategies used by people with ADHD (Mitchell et al., 2016). One study identified the important of physical activity to manage the more disruptive symptoms of ADHD, which may speak to the value of one participant's gum-chewing for stimulation (Hoza et al., 2016).

Being a self-advocate. A pervasive theme throughout participants' narratives centred on needing to stand up for themselves. For example, Cora had to advocate for herself to return to work following a leave of absence. In other words, all participants voiced that they are self-advocates to achieve their goals and be successful.

Somewhat surprisingly, there is a considerably amount of research on self-advocacy of individuals with ADHD or disabilities, particularly in the realm of post-secondary. Kimball et al.

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(2016) studied student activists and identified key self-advocacy skills, such as role modelling, doing, storytelling, and education. While these methods are not explicitly voiced by participants as the women were not speaking about activism experience, there is evidence in role modelling and storytelling as they share their stories with others who are in a similar situation.

A more recent study took a more measured approach to defining self-advocacy in the context of ADHD, although not specifically for women. Pfeifer et al. (2021) developed a model of self-advocacy which included items such as communication, view of disability, and agency, and noted that these factors influence the sense of comfort and security felt by an individual with ADHD.

Limitations

This study's aim was to shine an exploratory lens on the lived experiences of women with ADHD. However, due to the qualitative nature of this study, it would be impossible to include a representative sample of women living with an ADHD diagnosis. More specifically, the four participants of this study happened to all be reasonably successful, if successful can be measured by holding a degree from a post-secondary institution. The sample included in this study merely provides a brief snapshot of four women, and future research in this area could benefit from wider diversity. Furthermore, due to time limitations and restrictions imposed by public health organizations in light of the COVID-19 pandemic, only four women were interviewed and, as such, the study lacks heterogeneity and generalizability.

The COVID-19 pandemic also limited the methods with which I could interview participants. At the time of interviewing, the Research Ethics Board at the University of Ottawa had strict protocols in place to limit in-person interview protocols. Additionally, I was restricted by public health orders in my region. Thus, both recruitment and interviews had to take place

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online and virtually which can sometimes hinder organic conversation and the ability to note body language not otherwise noticed on a video-call. At times, there were technical difficulties which impeded understanding.

Criteria for the study required participants to have a diagnosis of ADHD, which is potentially limiting considering the fact that so many women go about life not aware of that they may be struggling with symptoms of ADHD. Furthermore, participants volunteered and thus self-selected to participate in the study – it could be inferred that more introverted individuals might not have been interested in participating.

It should also be noted that the ultimate question posed was broad and therefore did not permit for greater detail into certain constructs. By no means were follow-up questions exhaustive and this study itself only sheds a thin light on women with ADHD and a general idea of how they live their lives.

Clinical Implications

This study provided an avenue for women with ADHD to speak openly about their experiences, when otherwise they generally face little recognition in the research landscape as well as clinically in practice. Throughout this section and the last's presentation of results, I have provided interpretations of how participants view themselves, how they manage their diagnosis, and how they experience it. What remains clear is that women experience ADHD in a way that is fundamentally different from the way men experience the diagnosis. As such, treatment and interventions should be approached in a fundamentally different way and clinical practitioners, including psychotherapists, should be mindful of how they conceive ADHD and its symptoms.

Curious and interesting to this study was participants' narratives of intense, acute emotional experiences, which could be linked to and acknowledged as Rejection Sensitive

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Dysphoria (RSD). As discussed earlier, RSD is unique and should be understood as a key symptom of ADHD. Considering this, when practitioners, be they mental health professionals or physicians, assess women with ADHD, they should be considering this symptomatology in conjunction with more “traditional” symptom criteria for the diagnosis.

One far-reaching implication is the call to action on researchers, scientists, physicians, psychotherapists, and everyone in between to recognize the gender gap in research, specifically as it related to ADHD. It is neglectful as a society to maintain a sexist exclusion of a major demographic only for reasons of being too challenging. By ignoring the experiences of these women, society is licensing their continued suffering and lack of support.

Directions for Future Research

It goes without saying that there are many avenues down which future researchers and clinicians might consider exploring, as it related to ADHD in women. Considering the endless possibilities, I note in this section only future directions that may seem feasible or reasonable in view of the study at hand.

First, it may be worth exploring further the symptom of Rejection Sensitive Dysphoria (RSD). The research on this topic alone is lacking and further research as it relates to women’s experiences may provide further explanation around why women and men have radically different ADHD presentations. Furthermore, much of the current research centres around children and adolescent in educational settings; it would be potentially worthwhile to examine older adults with ADHD in different settings, in order to offer a more wholistic perspective of the diagnosis.

Final Remarks

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Acknowledging that women as a demographic are underrepresented and ignored with regards to healthcare and health-related research, this study proposed a focus on women's issues. Furthermore, following important consultation with the current relevant literature, it became abundantly clear that an important diagnosis such as Attention-deficit/hyperactive disorder (ADHD) in women has been overlooked by doctors and other health professionals. Without the proper and appropriate treatment and support, ADHD can have detrimental lifelong consequences. Women with ADHD face exceptional challenges as their symptomatology and presentation differs significantly from the presentation of the disorder among boys and men, as presented in the research above.

The value of this study lies in the knowledge that future researchers and health professionals may now become more aware and concerned with how ADHD presents itself in the woman population, in addition to how women with the disorder may or may not struggle. By shedding light on this historically overlooked population, women living with ADHD will hopefully be able to garner more support for their case and receive the professional support that is necessary for their success overall. By extension, women's health issues will be acknowledged, and people will be encouraged to reevaluate the meaning of gender within the context of health, thereby understanding that it can and does make a difference. The hope is that more concrete supports and resources can be developed to help women with ADHD, instead of being ignored in favour of boys and men with the same diagnosis, as has been the trend for centuries.

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Appendix A: Research Ethics Board (REB) Certificate

17/12/2020

Université d'Ottawa

Bureau d'éthique et d'intégrité de la recherche

University of Ottawa

Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-11-20-6331
Titre du projet / Project Title	Living as a Woman with ADHD: Experiences, Challenges, and Adaptive Strategies
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	17/12/2020
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	16/12/2021

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Erika MCDONNELL	Faculté d'éducation / Faculty of Education	Chercheur Principal / Principal Investigator
André SAMSON	Faculté d'éducation / Faculty of Education	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154 550 Cumberland Street, Room 154
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Appendix B: Recruitment Text

Hello!

My name is Erika McDonnell and I am a candidate for the MA in Counselling Psychology at the University of Ottawa, under the supervision of Dr André Samson. I am conducting a study examining the experiences of women with an ADHD diagnosis. I am seeking 4 to 6 women-identifying people to participate in a 45-60 minute interview (via phone or Zoom) to speak about their experiences with ADHD.

In order to participate, you must meet the following criteria:

1. Self-identification as a woman
2. Be between the ages of 18 and 60
3. Possess an ADHD diagnosis from a professional (e.g., doctor, psychologist, etc.)
 - a. The diagnosis may have been given at any point during your lifetime

If you are interested, please send me a message at [e-mail redacted].

Kind regards,
Erika McDonnell

Appendix C: Informed Consent

Consent Form

Title of the study: **Living as a Woman with ADHD: Experiences, Challenges, and Adaptive Strategies**

Erika McDonnell
M.A. Candidate
Counselling Psychology
University of Ottawa
Tel: [number redacted]
E-mail: [email redacted]

André Samson
Professor, Thesis Supervisor
Counselling Psychology
University of Ottawa
Tel: [number redacted]
E-mail: [email redacted]

Invitation to Participate: You have been invited to participate in the abovementioned research study conducted by Erika McDonnell called Living as a Woman with ADHD: Experiences, Challenges, and Adaptive Strategies. The research project is being conducted as a requirement and in partial fulfillment for Erika McDonnell's completion of the M.A. degree in Counselling Psychology at the University of Ottawa.

Purpose of the Study: The purpose of the study is to explore the experiences of adult women living with an ADHD diagnosis, including the challenges they face in healthcare and workplace settings as well as the strategies they use to cope with these challenges. The goal of this study is to expand on the present knowledge regarding women living with ADHD, including the potential issues they might face in different contexts. The importance of this study lies in the fact that specific research on ADHD as it relates to women is limited, thus potentially enabling healthcare and mental health professionals to better support women clients living with ADHD by responding to their struggles in a more clinically informed way (e.g., ADHD support programs).

Participation: If you agree to participate in this study, you will be interviewed about your experiences as a woman living with an ADHD diagnosis. The interview will be conducted in English and will last approximately 45 to 60 minutes. The interview will be audio-recorded for transcription at a later date. All interview transcripts will be anonymized with any identifiable information removed. Following transcription, you will be sent an encrypted PDF of the document to verify accuracy of interview content. You will have seven (7) days to review and return the transcript with any adjustments. Transcripts will be kept electronically, and password protected.

Risks: Your participation in this study will require you to disclose personal information about experiences that may elicit emotional discomfort, which has the potential to persist following the actual interview. While the risk to your emotional and psychological health, you can inform the researcher at any moment during the interview process of any feelings of discomfort you may be experiencing. Following the interview, you will be provided with the contact information of national distress services should any emotional discomfort persist and/or emerge.

Benefits: Your participation in this study will provide you with the opportunity to reflect on and critically engage with your experiences as a woman living with an ADHD diagnosis. Furthermore,

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your participation will enable you to contribute to the knowledge regarding ADHD as it relates to women. This information has the potential to be beneficial for future researchers, clinicians, and policies related to supporting and better understanding the experiences of women living with ADHD.

Confidentiality and anonymity: To maintain confidentiality, all identifiable information from audiotapes and the resulting transcripts will be removed. The contents of the audiotapes and transcripts will only be accessible to the researcher and thesis supervisor, and anonymized versions of selected parts of transcripts will only be used in the resulting thesis paper. Each participant will be assigned a number in an effort to maintain anonymity.

Conservation of data: The data collected will include an audio recording of the interview and a transcription resulting from the interview. All original data will be securely stored on an encrypted password-protected hard-drive kept by the researcher, Erika McDonnell. The data will be accessible only by Erika McDonnell and the thesis supervisor, Dr. André Samson. The data will be maintained and kept for five years following the study. After the five years, the data will be destroyed and disposed of in an appropriate manner.

Voluntary Participation: Your participation in this study is entirely voluntary and you are free to withdraw at any point. This means you can choose to withdraw your participation from the interview regardless of previous consent. In the event that you choose to withdraw, your data will be destroyed and not utilized for the purposes of the study. You are free to ask the researcher questions at any time and you can refuse to answer any questions without consequences.

Two copies of this consent form exist, of which one is yours to keep. If I have any questions about the study, I may contact the researcher or his supervisor. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5

Tel.: (613) 562-5387

Email: ethics@uottawa.ca

Acceptance: I, _____, agree to the procedures described above and to participate in the above research study conducted by Erika McDonnell, M.A. Candidate of the Faculty of Education, whose research is under the supervision of Dr. André Samson.

Participant's signature:

Date:

Researcher's signature:

Date:

Appendix D: Semi-Structured Interview Protocol

Study: Living as a Woman with ADHD: Experiences, Challenges, and Adaptive Strategies

Date: _____ Interviewee #: _____

A) Information for Participants

The purpose of the study is to explore the experiences of adult women living with an ADHD diagnosis, including the challenges they face in healthcare, the workplace, and at home, and the strategies they use to cope with these challenges. The goal of this study is to expand on the present knowledge regarding women living with ADHD, including the potential issues they might face in different contexts. The information resulting from this study has the potential to enable healthcare and mental health professionals to better support women clients living with ADHD by responding to their struggles in a more clinically informed way, such as through the development of new approaches and support programs.

B) Review Informed Consent

Before we begin our interview, I would like to take the time to review the informed consent form with you. I will provide you with a copy of the document to have with you after the interview. If you have any questions or concerns before, during, or after the interview, please do not hesitate to let me know.

C) Collection of Demographic Information

To start, I am going to ask you some demographic questions that might be helpful in understanding your experiences as a woman with ADHD.

1. How old are you? _____
2. What is your profession? _____
3. What are your educational qualifications? _____
4. What is your formal ADHD diagnosis? _____
 - a. At what age/How many years ago did you receive your diagnosis? _____
5. What is your marital status? _____
6. Do you have children? _____
 - a. If YES, how many? _____

D) Contextual Interview Questions

Now, I am going to ask you some questions regarding your experiences as woman living with an ADHD diagnosis. It is possible that the content may elicit some emotional discomfort. If, at any time, you feel uncomfortable or would like to pause the interview, please let me know. In an

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effort to ensure accuracy, the interview will be audio-recorded and transcribed at a later date. All identifiable information will be removed to maintain anonymity.

1) Background with ADHD

- a. What was your childhood like? Consider school experience and at-home experience.
- b. Tell me about your ADHD diagnosis and your symptoms.

2) Healthcare Experience

- a. What prompted you to see a medical professional/receive a diagnosis?
- b. Describe your relationship with your medical provider(s), presently and over time.
- c. To what extent do you feel supported by your medical provider and healthcare system in your diagnosis?

3) Experiences and Challenges at Work and at Home

- a. How would you describe your work-life balance?
- b. How do you experience your ADHD at work, if at all?
 - i. What do you think are the biggest challenges for you at work, if any?
- c. How do you experience your ADHD in your home life, if at all?
 - i. What do you think are the biggest challenges for you at home, if any?

4) Strategies

- a. How have you adapted to living with ADHD?
- b. What coping strategies or mechanisms do you rely on to manage your ADHD?
 - i. Are there specific strategies you use at work? At home?
- c. What are other sources of support for you, if any?

5) Wrap-Up

- a. Is there anything else you would like to add that you feel I may have missed?