Investigating the Impact of the Current ADHD Diagnostic Process on Women in Canada

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Abstract

This thesis investigates the impact of Canada's ADHD diagnostic process on women, focusing on systemic, gendered, and sociocultural factors that lead to delayed or missed diagnoses. Through a review of literature and interviews with women diagnosed in adulthood, the study examines seven themes: self-blame, systemic ableism, misogyny, reaching a breaking point, community importance, grief, and self-acceptance (Mowlem et al., 2019; Quinn & Madhoo, 2014). Using Interpretative Phenomenological Analysis (IPA), feminist, and critical disability theories, the research explores intersectional barriers affecting women's access to ADHD diagnosis and support in Canada (Smith et al., 2009). Findings indicate that current diagnostic criteria, designed around male presentations, often overlook women's unique ADHD symptomology, resulting in underdiagnosis and misattribution to other conditions (American Psychiatric Association, 2022; Agnew-Blais et al., 2016). This often leads to emotional distress and inadequacy, compounded by societal expectations (French et al., 2019). The study advocates for gender-sensitive diagnostic criteria and support resources. Practical recommendations include healthcare education reforms, inclusive diagnostic tools, and peer support networks. This Canadian-focused research aims to enhance diagnostic practices and improve experiences for women with ADHD (Espinet et al., 2022).

Keywords: ADHD, diagnosis, women, Canada, systemic barriers

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Introduction

Background

The historical association between hysteria and the female experience dates back to ancient Greece, where the two became deeply entwined (Ussher, 2013). Hysteria, a multifaceted diagnosis that persisted well into the 21st century, was frequently used by physicians to pathologize women who deviated from societal expectations regarding their behaviour and cognition (Tasca et al. 2012). This disturbing history helps to shed light on a prevailing misconception –that widely used contemporary diagnostic tools, such as the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) (American Psychiatric Association, 2022), are exempt from gender bias and universally applicable. It is essential to note that the DSM itself has a complex history, including problematic beginnings. It was not until the DSM's third edition in 1980 that the diagnostic category of hysterical neurosis (hysteria) was removed (Tasca et al., 2012). This unsettlingly recent history, occurring less than half a century ago, underscores the urgent need to critically evaluate our current diagnostic tools and processes and their effectiveness in diagnosing conditions in women traditionally perceived as 'male disorders', such as attention deficit hyperactivity disorder (ADHD).

Background of the Gender Diagnostic Gap

ADHD, as defined by the American Psychiatric Association (2022), is a neurodevelopmental disorder characterized by consecutive patterns of inattention, hyperactivity, and impulsivity. In the context of the historical prevalence of gender bias within diagnostic practices, it is important to recognize its continued presence in contemporary psychiatric assessments such as the ones used to diagnose females with ADHD. Despite advancements in the field of mental health and the development of diagnostic tools, a diagnostic gap continues to

disproportionately affect females, particularly in the case of diagnoses like ADHD. This diagnostic gap is evidenced by a significant 3:1 ratio of male-to-female ADHD diagnoses before adulthood (Kessler et al., 2006).

The existence of this diagnostic gap is made apparent through research, such as a 2019 study by Mowlem et al. Mowlem et al. (2019) delved into the multifaceted factors, including symptomology and gender, that influence a child's likelihood of receiving an ADHD diagnosis. Their findings shed light on the impact of gender-related factors within the diagnostic process, factors that contribute to the underdiagnosis or delayed diagnosis among females. One important discovery by Mowlem et al. (2019) was that females often exhibited more pronounced 'emotional problems' when compared to males, which, in turn, tended to “obscure” their ADHD symptomology when using current diagnostic practices. Mowlem et al. (2019) suggest that the way in which girl’s symptoms manifest emotional may also be perceived by parents and health care professionals as internal manifestations of conditions such as anxiety and depression due to their presentation similarities. It's worth noting that when females receive an ADHD diagnosis after childhood (typically at or after age 10), their ADHD symptomology often manifests as anxiety and depression, as reported by Agnew-Blais et al. (2016). Furthermore, Mowlem et al. (2019) revealed that parents consistently rated hyperactive/impulsive symptoms in their female children lower when compared to males, which in turn complicates the process of achieving an accurate diagnosis. These findings raise questions about whether the current diagnostic criteria rely too heavily on biased perceptions of symptomology and if they are able to accurately represent the female ADHD experience.

Carbonneau et al. (2021) continue to question the differences in ADHD symptomology across the sexes through their meta-analysis. This comprehensive analysis goes beyond

statistically quantifying differences and brings to light the 'unique' symptomology that characterizes the experience of females with ADHD. The meta-analysis reveals that the presentation of ADHD in females often deviates from traditional male symptom patterns, suggesting that the current diagnostic criteria, which predominantly draws from male-centric symptomology, inadequately captures the breadth of the female experience with ADHD (Carbonneau et al., 2021).

Exploring the Diagnosis Gap

The evolving understanding of female ADHD symptomology raises critical questions regarding the accuracy and adequacy of current diagnostic criteria and assessment processes. To address these concerns, it is essential to understand the underlying factors and gender-specific symptomology contributing to the diagnosis gap. It is also crucial to begin to explore the unique challenges women face in receiving an accurate ADHD diagnosis within the influence of referral patterns within primary care settings. This diagnostic gap becomes especially evident when we consider the prevalence of individuals being diagnosed with ADHD at a 3:1 ratio compared to others before adulthood (Kessler et al., 2006). It is against this backdrop of statistical gender disparity that we delve into the underlying factors contributing to the diagnostic gap.

Nussbaum's (2012) thorough literature review challenges the historical perception of ADHD as primarily affecting males and provides a critical counterpoint by highlighting the accumulating research that suggests a nearly equal prevalence between men and women with ADHD in adulthood, as supported by findings from Faraone et al. (2000). Beyond this, Nussbaum (2012) underscores the critical importance of comprehending the gender-specific presentation of ADHD, introducing the concept of 'masking.' This phenomenon suggests that emotional challenges experienced by women can obscure the recognition of their underlying

ADHD symptomology. Consequently, this often leads to delayed diagnosis or even misdiagnosis. This concept of 'masking' is crucial, as it contributes to the understanding of the increasing prevalence of ADHD diagnoses among females as they age. When people age, they tend to develop enhanced social and articulation skills; this, in turn, allows females the ability to effectively communicate their ADHD symptoms in ways that might not have been captured by the diagnostic tools used during their youth.

Building upon these critical insights, Quinn and Madhoo's (2014) research further explores gender-specific presentation and symptomology of ADHD. Quinn and Madhoo (2014) underscore the varying attitudes and clinical perceptions concerning ADHD based on the gender of the individual under examination. This observation aligns with findings from previous studies, highlighting disparities in diagnosis and management based on gender (French et al., 2019). It becomes evident that traditional diagnostic approaches neglect the specific needs/experiences of females with ADHD.

One notable finding from Quinn and Madhoo (2014) is the 'low index of clinical suspicion' that females often encounter, leading to a diagnosis perceived as 'subthreshold' due to their increased inattentiveness over hyperactivity/impulsivity in their symptom presentation. This corroborates findings from earlier studies that underscore the different presentation patterns of ADHD between males and females (Nussbaum, 2012; French et al., 2019). The unique female experience often goes unnoticed, resulting in diagnostic overshadowing—a concept discussed by Hallyburton (2022) as the misattribution of physical or psychological symptoms to existing conditions, which, in the context of ADHD, can mean that emotional challenges in women mask the recognition of their ADHD symptoms, leading to delayed diagnosis or misdiagnosis. It is essential to recognize that the impact of delayed diagnosis extends beyond mere oversight but

significantly influences the long-term outcomes for women with ADHD (Mao & Findling, 2014).

In addition to the diagnostic intricacies experienced by women and girls with ADHD, comorbidities further complicate the diagnostic process. Quinn and Madhoo (2014) emphasize that anxiety and depression are frequently concurrent with ADHD in female patients. This dual diagnosis is not an isolated finding; it has been corroborated by studies such as Mao and Findling (2014), which underscore the substantial emotional impact of ADHD diagnoses in adulthood. The presence of these comorbidities can lead to missed or incorrect diagnoses, highlighting the critical importance of recognizing and addressing the emotional well-being of individuals throughout the diagnostic process (Waite, 2007a; Waite, 2007b).

Consequently, accurate ADHD diagnosis in women and girls necessitates a profound understanding of the unique symptom presentation and gender-specific factors influencing the condition. Coexisting anxiety and depression are pervasive in female patients with ADHD, emphasizing the need for thorough and holistic evaluation, even when academic achievements may not raise initial concerns (Mao & Findling, 2014). Thus, the research conducted by Quinn and Madhoo (2014) underscores the significance of recognizing gender-specific nuances in the diagnosis and management of ADHD, a sentiment echoed in various other scholarly inquiries on this subject.

Moreover, our understanding of the diagnostic gap in ADHD is enriched by a systematic review of barriers and facilitators to understanding ADHD in primary care (French et al., 2019). This review underscores the complexity of access to care for individuals with ADHD. Primary care practitioners often serve as the first point of contact for those seeking ADHD-related help, making their role in recognition, diagnosis, and referral vital. The review identifies key themes,

including the need for education, misconceptions and stigma, constraints with recognition, management, and support, and the importance of a multidisciplinary approach in ADHD care. Education of primary care practitioners emerges as a central theme, emphasizing the significant need for better training in recognizing diverse ADHD presentations and understanding gender-specific symptoms (French et al., 2019).

The collective findings from these sources and the systematic review (French et al., 2019) highlight the multifaceted factors contributing to the diagnostic gap in ADHD, which encompasses gender-based disparities, variations in referral patterns, and barriers within primary care settings. These factors underscore the urgency of a more refined and gender-sensitive approach to diagnosis, along with the importance of monitoring practice patterns and enhancing education. By comprehending these factors and their impact on diagnosis, we can take significant steps toward improving the diagnostic process for individuals with ADHD.

Impact of Late Diagnosed ADHD

The diagnostic gap in ADHD raises concerns not only about the accuracy of diagnosis but also about the potential long-term consequences of delayed recognition for females. Late-diagnosed ADHD can have significant implications for individuals, affecting their daily lives, mental health, and overall well-being. While there is limited research specifically addressing the outcomes of late diagnosis, we can draw upon findings from existing studies to shed light on this issue.

Late diagnosis of ADHD often means that the person has coped with their symptoms for an extended period, potentially without the appropriate support and interventions. As Mao and Findling (2014) emphasize in their study on comorbidities in adult ADHD, individuals with late-diagnosed ADHD may experience a range of comorbid conditions, such as mood disorders,

anxiety, substance abuse, and difficulties in interpersonal relationships. Moreover, late diagnosis of ADHD can have significant academic and occupational implications. Individuals who were not diagnosed during their formative years may have struggled in school or faced career difficulties, as highlighted by Waite (2007a) in their research on women with ADHD. This research emphasizes that the diagnosis often serves as an explanation for their symptoms and can help the individual to come to terms with the barriers they faced throughout their life.

Late diagnosis also places a considerable burden on individuals' mental health. The additional stress and challenges arising from unmanaged ADHD symptoms, comorbid conditions, and academic or occupational difficulties can contribute to elevated rates of anxiety and depression among late-diagnosed individuals (Mao & Findling, 2014). Late-diagnosed ADHD can have a multifaceted impact on individuals, affecting their mental health, academic and occupational outcomes, and overall quality of life. While more research specifically focused on the long-term consequences of late diagnosis is needed, the available literature suggests that timely and effective recognition and intervention are crucial.

Calls for Diagnostic Reform

The persisting diagnostic disparities and the implications of late-diagnosed ADHD have prompted numerous researchers to advocate for a reform in the diagnostic process. These calls for change have come from various perspectives within the healthcare and educational fields, emphasizing the urgent need to address the challenges associated with ADHD diagnosis.

Adler et al. (2019) conducted a comprehensive study delving into healthcare providers' perspectives regarding the diagnosis and support of adults with ADHD. Adler et al. (2019) found that psychiatrists displayed significantly more confidence in diagnosing ADHD compared to non-psychiatrists. This distinction in diagnostic confidence is particularly relevant given that

General Practitioners (GPs) deliver 66.7% of ADHD diagnoses in Canada (Espinet et al., 2022). Furthermore, psychiatrists were more likely to screen and evaluate patients with comorbid conditions like depression and anxiety, which is essential in the context of adult ADHD diagnosis (Mao & Findling, 2014). The difference in diagnostic confidence between psychiatrists and non-psychiatrists, particularly General Practitioners (GPs) who play a critical role in diagnosing and supporting people with ADHD, underscores the necessity for diagnostic reform. It is essential to ensure that healthcare providers at the forefront of delivering diagnoses have the confidence and competence required for accurate assessments.

In their educational context study, Lynch and Davison (2022) address the gendered expectations related to recognizing ADHD in young women. Their research sheds light on the unique challenges faced by females with ADHD, especially young girls. By revealing how gender biases can influence the diagnostic process, their study implicitly advocates for reform within educational settings to rectify gender disparities in the recognition of ADHD. Lynch and Davison (2022) research conducted in Ireland examines the social and academic experiences of 17 young women aged 13 to 20, all medically diagnosed with ADHD. The research findings expose the substantial and inhibiting impact of gender stereotypes on these participants' journeys toward obtaining an ADHD diagnosis. Both teachers and clinicians often struggled to recognize the behaviours displayed by the participants as symptomatic indicators of the condition (Lynh & Davidson, 2022). These findings suggest the presence of an inequitable gendered cycle in how we generally perceive, identify, and comprehend ADHD, emphasizing the urgent need for reform and a greater understanding of females' experiences with ADHD.

Sharma et al. (2021) raised a critical question about the validity of applying the age-of-onset criterion to older adults being evaluated for ADHD. The authors emphasize that relying on

retrospective reports of childhood symptoms, especially in older adults, may impede the accurate diagnosis and supports provided for ADHD (Sharma et al., 2021). The study calls for a reconsideration of the diagnostic criteria for ADHD, particularly when assessing older adults.

In a complementary longitudinal study, Von Wirth et al. (2021) explore the accuracy of retrospective recall of childhood ADHD symptoms and its implications for the age-of-onset criterion. Their findings highlight the presence of a recall bias in adult patients, particularly when self-reporting childhood symptoms. This is especially concerning, as stated before; the majority of females diagnosed with ADHD are diagnosed after childhood (Kessler et al., 2006). It is clear that the accuracy of retrospective recall of childhood symptoms disproportionally affects females as a result of the diagnosis gap. These studies collectively underscore the complexity and potential limitations of using the age-of-onset criterion in older adults, calling for a more refined and age-sensitive approach to ADHD diagnosis, one that considers the unique characteristics and challenges of this specific demographic (Sharma, Lavoie, & Callahan, 2021; Von Wirth et al., 2021).

Construct of Current Diagnostic Practices

Current diagnostic practices for ADHD often emphasize the perceived 'deficits' of ADHD, focusing on symptoms like inattention, hyperactivity, and impulsivity (American Psychiatric Association, 2022). This deficit-oriented approach is deeply embedded in the diagnostic criteria outlined in widely used manuals such as the DSM-5, which predominantly relies on symptomatology that reflects a male-centric view of ADHD (American Psychiatric Association, 2022). However, this focus on deficits alone does not capture the full spectrum of the ADHD experience, particularly for women, whose symptoms may manifest in less overt ways such as inattentiveness or emotional dysregulation (Mowlem et al., 2019).

Drawing from critical disability studies, recent research has highlighted the importance of recognizing the positive characteristics and strengths of people with ADHD, such as creativity, resilience, empathy, and the ability to think divergently (Schippers et al., 2022). These strengths often go unrecognized in clinical settings, where the primary focus remains on mitigating deficits rather than appreciating the broader capabilities of people with ADHD. For instance, Schippers et al. (2022) found that many people with ADHD reported a strong sense of empathy and high levels of energy, which they viewed as assets rather than impairments. By failing to acknowledge these traits, current diagnostic practices may contribute to a limited understanding of ADHD that reinforces stigma and neglects the lived experiences of those diagnosed.

Incorporating critical disability theory into the diagnostic process advocates for a shift from a purely deficit-based approach to one that considers the person's strengths and how these can be leveraged in their personal and professional lives (Goodley, 2014). This approach aligns with the social model of disability, which emphasizes the need to adapt societal structures to support people’s abilities rather than solely focusing on their limitations (Beresford, 2013). By adopting a strengths-based perspective, the diagnostic process can become less stigmatizing and more inclusive, providing a comprehensive view that better reflects the diverse experiences of those with ADHD, particularly women whose symptoms may not fit the traditional diagnostic mold.

For women whose ADHD symptoms are often overshadowed by emotional issues or perceived personality traits, such as being 'lazy,' a strengths-focused diagnostic model could significantly alter their diagnostic journey. Mowlem et al. (2019) noted that females with ADHD often exhibit heightened emotional problems, which can obscure their core ADHD symptoms under current diagnostic criteria. A revised approach, informed by critical disability theory,

would not only aim to identify these symptoms but also value the unique strengths that accompany ADHD, ultimately promoting a more holistic and equitable diagnostic experience.

Thus, this study's emphasis and inquiry into creating a more inclusive diagnostic process aligns with the broader calls for reform within critical disability studies, aiming to shift from a narrow, deficit-oriented perspective to one that fully appreciates the diverse strengths and experiences of people with ADHD (Goodley, 2014; Thomas, 2007). This approach is not only essential for reducing stigma but also for fostering a more person-centered diagnostic and support process that acknowledges the full range of a person's capabilities.

Gaps in Knowledge

The female experience of ADHD and the diagnostic process is significantly under-researched globally. In considering the limited amount of research we have regarding the diagnostic process itself, there is an even more of limited number of studies that uses a feminist perspective (Lynch & Davison, 2022). This research gap is inherently problematic because in order to accurately support women in any facet, it is critical to understand the social, political and economic factors that impact their daily lives Moreover, while many researchers have called for ADHD diagnostic reform, many - if not all - fail to ask women directly affected by the system for their suggestions. By not asking these women for suggestions or listening to their stories we as an academic community lose the opportunity to learn how the system is affecting women and what they feel can be done to improve it for future generations. While it is important for researchers to speak out about the ineffective system of diagnosing women with ADHD, in order to support the current and future generations of women with ADHD efforts must be made to adapt the system and create tangible resources for women going through the diagnostic process.

The identified gaps in knowledge, including the limited Canadian-centric research and the scarcity of feminist perspectives, are particularly relevant to the research questions guiding this study. Specifically, the lack of Canadian-centric research on ADHD diagnosis in women means that much of the existing literature fails to account for unique factors within Canada's healthcare system, such as the publicly funded structure and geographic challenges that affect access to care. Unlike in the United States, where individuals can select specialists, Canadians often experience longer wait times and limited specialist access, impacting the timeliness and accuracy of diagnoses (Espinet et al., 2022). This difference underscores the importance of conducting research within the Canadian context to develop tailored solutions that reflect the specific systemic barriers faced by Canadian women.

Additionally, the need for a feminist perspective is crucial because current diagnostic practices often fail to recognize the gender-specific manifestations of ADHD, influenced by social, political, and economic factors (Lynch & Davison, 2022). By directly engaging with women who have navigated the diagnostic process, this study aims to provide insights that are currently missing in the literature, such as how gender biases and systemic ableism intersect with ADHD diagnosis. This approach not only fills a gap in existing research but also seeks to empower women by valuing their lived experiences and recommendations for improving diagnostic practices.

This study offers a unique opportunity for women to share their experiences about the diagnostic process and give their opinions on what can be done to adapt the current process. It is important to note while the study heavily critiques the current diagnostic process for women with ADHD in Canada the aim of this study is to support women within the current diagnostic process. This deliberate choice is made because while the development of new diagnostic criteria

and processes is ideal, it also takes a considerable amount of time and money, and as previous research states women need help now navigating our current system. While this study will highlight the need for extensive diagnostic reform, the goal is that the results can be used as a leaping off point to create resources, tools, programs, etc., to support women through the current diagnostic process.

It is important to note that when compared to other countries Canada lacks research on ADHD in women. The majority of research on ADHD in women has been conducted outside of Canada in places such as the United States and England. While Canadians may often use research from other countries, Canada is inherently unique as a country. Especially when compared to the United States Canada's health care system is systematically different. In the United States health care is privately operated which creates a multitude of barriers to health care but also provides people the opportunity to select their health care provider. When given the opportunity to select a healthcare provider people have the opportunity to select specialists who have diagnostic experiences in their suspected disorder, which inherently can change their diagnostic experience. While in Canada healthcare is government-funded, citizens often lack the ability to choose their healthcare provider and often experience egregiously long wait times to connect to a specialist. This means that women who have experienced the diagnostic system in the United States will more than likely have a different experience than women in Canada. Even when examining the similarities of the healthcare systems between England and Canada it is important to note Canada's geography. Canada is over 40 times as big as England with a much smaller population, which means many rural Canadians simply may not have physical access to a variety of professionals to get an ADHD diagnosis. Canada's physical landscape inherently affects our healthcare system which in turn will affect women's experience with ADHD

diagnosis. While it is helpful to use research from other countries, there is also a clear need for Canadian-centric research that inculpates the intricoes of Canadian life.

Moreover there is a notable absence of research that recognizes and addresses the disability-related aspects of ADHD diagnosis. While ADHD is a well-known condition, there remains a significant need to explore how gender biases and ableist stereotypes influence the diagnostic process, especially among young women and girls (Ussher, 2013). By employing a critical disability lens, inspired by Goodley (2014), the study aims shed light on how ableist language, stereotypes, and disability-related biases intersect with the experiences of females with ADHD (Schalk, 2013). This critical perspective reveals the importance of considering disability not merely as a medical condition but as a social construct that influences how females with ADHD are perceived and treated within the healthcare system and society.

As stated above, when examining female experiences it is essential to acknowledge and explore the effect gender has on the female experience of receiving and ADHD diagnosis. It is theoretically impossible to examine the female diagnostic experience without acknowledging how gender affects every aspect of their lives including their own and other's perception of ADHD. The intersection of feminism and disability studies offers a unique perspective that can contribute to a more comprehensive understanding of the gendered and disability-related challenges that women and girls with ADHD face in the diagnostic process in Canada. The feminist and critical disability lens can provide a critical perspective through which these biases can be examined, and the experiences of females with ADHD can be understood more deeply. This gap highlights the need for research that advocates for recognizing gender disparities, disability-related biases, and promotes equity in the diagnostic process.

The importance of giving the people most affected by the diagnostic process a voice cannot be overstated. People who have undergone the process of ADHD diagnosis have unique insights to share (Schrevel et al., 2016). By providing a platform for females with ADHD to share their experiences and recommendations, the study can empower them and contribute to a more patient-centered and inclusive approach to ADHD diagnosis. This aspect of involving the voices of those directly affected by the diagnostic process is often missing in the existing literature (Young et al., 2008).

In this context, using a critical disability and feminist lens can help illuminate the systemic and societal barriers that individuals with ADHD, particularly women and girls, encounter within the diagnostic process. These barriers can include disability-related stigma, gender biases, and a lack of patient-centered care. This approach can help address these issues in research and clinical practice, ultimately leading to a more inclusive and equitable diagnostic process for females with ADHD.

Significance of Proposed Research

The significance of the proposed research lies in its potential to address gender disparities in the diagnosis of ADHD and to empower women who have been diagnosed with ADHD in adulthood. Historically, ADHD has been perceived as primarily affecting males. Nevertheless, evolving research findings challenge this misconception, indicating that the number of women with adult ADHD approaches parity with that of men (Kessler et al., 2006). Despite this shift, women still confront unique impediments when seeking ADHD diagnoses (Quinn, 2008). Consequently, understanding the evolving landscape of ADHD diagnosis becomes pivotal to ensure that women promptly and accurately receive their diagnoses. By immersing itself in the

experiences of women diagnosed with ADHD, this research adds a valuable contribution to the ongoing discourse on gender disparities in ADHD diagnosis (Nussbaum & Fisher, 2019).

To delve into the lived experiences of women with ADHD in Canada, the study employed the Interpretative Phenomenological Approach (IPA; Smith et al., 2009). IPA is designed to recognize the idiosyncrasies within everyone's ADHD journey and to acknowledge their narratives accurately. Through the amplification of participants' voices, the research confers validation upon the diverse experiences intertwined with ADHD diagnoses among women (Smith et al., 1999). This validation can exert a profound impact not only on the lives of the participants themselves but also on the broader comprehension of the emotional, social, and psychological dimensions of ADHD diagnosis. In doing so, the research serves as a medium through which people can express their experiences, which often remain unnoticed within traditional diagnostic paradigms (Braun & Clarke, 2006).

However, the study goes beyond merely identifying the issues surrounding ADHD diagnosis among women. It attempted to elicit recommendations from women who have been diagnosed with ADHD, aiming to enhance the existing diagnostic processes in Canada. These recommendations are poised to provide practical insights, serving as a valuable resource for healthcare professionals, researchers, and policymakers alike. Implementation these recommendations may translate into applied tools to support women in Canada in navigating the current diagnostic process and inspire long-term diagnostic reform.

This research introduces an additional layer of significance is introduced through the Canadian-centric perspective undertaken by this research. While existing ADHD research predominantly originates from the United Kingdom and the United States, the unique experiences and healthcare systems specific to Canada often remain overlooked. This research

takes a dedicated Canadian approach, thereby addressing a critical gap in the existing literature. By immersing itself in the Canadian context, it contributes substantially to the body of knowledge on ADHD diagnosis within the Canadian healthcare system. This contribution is essential in alleviating the limitations associated with research that predominantly concentrates on the experiences of individuals in non-Canadian settings.

This study's commitment to Knowledge Mobilization (KMb) strategies aims to have its impact reverberate beyond the research itself. Recognizing the importance of engaging a broad spectrum of vested parties (woman with ADHD, family physicians, educators, policy makers and the broader Canadian public), including researchers from various disciplines, the research findings are disseminated through channels such as conferences, academic journals, and social media platforms. This comprehensive approach stimulates multi-disciplinary collaboration and ensures the accessibility of the research findings to a wide-ranging audience of stakeholders.

In summary, the study encompasses a spectrum of significance, encompassing the resolution of gender disparities in ADHD diagnosis, validating individual experiences, practical recommendations, Canadian-centric insights, and extensive knowledge mobilization. The proposed research aims to bridge the existing gaps in knowledge and service delivery, effectively making a meaningful contribution to the field of ADHD research. Most importantly, it strives to enhance the diagnostic experiences of women diagnosed with ADHD in Canada, thus significantly improving their journey toward diagnosis.

Conceptual Frameworks

The study is guided by a multifaceted conceptual framework that incorporates three fundamental approaches to comprehensively examine the experiences of women diagnosed with

ADHD in Canada and address the associated gender disparities. This framework offers a holistic perspective that encompasses the practical, gendered, and inclusive aspects of ADHD diagnosis.

Interpretative Phenomenological Analysis (IPA)

In the context of this study, Interpretative Phenomenological Analysis (IPA) serves as the central qualitative research methodology (Smith et al., 2009). IPA is a pivotal choice, driven by its suitability for delving into the multifaceted and individualized experiences of women who have received ADHD diagnoses in Canada. This research approach resonates with the pragmatic paradigm that emphasizes the practical transformation of society (Goldkuhl, 2012). Kadelec, 2006 explains how John Dewy (a founder of pragmatism) utilizes the accounts of people's lived experiences to critically reflect of society. The study's utilization of lived experience to critique the current diagnostic process and develop strategies to support women through the process affirms the study's chose to use a pragmatic paradigm.

The pragmatic paradigm underscores the need for research to have a real-world impact, making IPA an ideal choice. In essence, it's a method that places the participants' perspectives at the forefront, acknowledging the richness and depth of their experiences. The research explores how these women perceive and construct meaning around the ADHD diagnostic process, acknowledging the significance of their voices and narratives in shaping the research.

By leveraging IPA, the study is focused on the real-life experiences of women with ADHD. This methodology is a powerful tool for amplifying their voices, ensuring that their stories are heard, and their insights acknowledged. As a result, the research is poised to generate valuable recommendations for improving the ADHD diagnostic process, informed by the very individuals who have navigated its complexities. It's a method that bridges the gap between

academic inquiry and tangible, practical change, aligning perfectly with the research's objectives and the lived realities of women with ADHD.

Feminist Theory

The research is underpinned by a feminist perspective that permeates every facet of the study, allowing for a nuanced examination of the gendered dimensions of ADHD diagnosis (Ussher, 2013; Tasca et al., 2012). Feminist theory, at its core, challenges traditional power structures and seeks to address inequalities stemming from patriarchal norms, particularly in healthcare systems that have historically marginalized women's experiences (Tasca et al., 2012). This framework recognizes that women's health concerns, including neurodevelopmental conditions like ADHD, are often misinterpreted or dismissed, leading to delayed or inadequate diagnoses (Ussher, 2013). Feminist theory advocates for research that centers women's experiences, challenges gender biases, and acknowledges the intersections of gender, class, and ability in understanding health disparities (Schalk, 2013).

Applying feminist theory to this study is essential, as the research delves into gender-specific issues embedded in the ADHD diagnostic process. This approach enables a critical exploration of how societal norms, power dynamics, and healthcare biases intersect with the diagnostic journey, often resulting in underdiagnosis, misdiagnosis, or diagnostic overshadowing for women (Ussher, 2013; Tasca et al., 2012). By employing feminist theory, the study not only highlights the distinct challenges faced by women with ADHD but also examines the systemic structures perpetuating these issues (Schalk, 2013). Feminist theory is crucial for unraveling the broader context that shapes the lives of women with ADHD, offering a lens that considers gender identity, empowerment, and equity (Ussher, 2013).

The act of creating research that centers on women's experiences, particularly in a field where female-centered studies are limited, is itself an act of feminism (Tasca et al., 2012). By positioning feminist theory as an essential framework, this study provides a platform to question and challenge traditional gender norms that influence the diagnosis and support available for individuals with ADHD, advocating for a shift toward more inclusive and responsive diagnostic practices (Schalk, 2013; Ussher, 2013).

Critical Disability Theory

Inspired by Goodley (2014), including a critical disability perspective, is central to the research framework. This perspective emphasizes the importance of embracing disability as an integral part of daily life, devoid of negative connotations (Schalk, 2013). Within this approach, there is a strong commitment to removing ableist language and perceptions in the research process (Nizza et al., 2021). Critical disability theory will play a pivotal role in shaping and refining the interview questions, as discussed in the methods section of the proposal. It will inform the development and adaptation of questions to ensure they align with the principles of inclusivity and a nuanced understanding of disability, thus enhancing the overall quality of the research.

This multifaceted conceptual framework offers a comprehensive lens through which to examine the complex phenomenon of ADHD diagnosis from a gendered, experiential, and inclusive perspective. The integration of these three approaches empowers the research to address the intricate dimensions of ADHD diagnosis in women in Canada, emphasizing the importance of practical change, gender analysis, and inclusivity. This framework ensures a well-rounded and robust exploration of the research topic.

A Multifaceted Approach

The integration of feminist theory and critical disability theory into the study's methodological approach provides a cohesive framework that informs every stage of the research process, from the formulation of research questions to the interpretation of data. By using Interpretative Phenomenological Analysis (IPA), this study explored the individualized and subjective experiences of women diagnosed with ADHD in Canada, a choice that directly aligns with the theoretical underpinnings of both feminist and critical disability perspectives (Smith et al., 2009).

Feminist theory, which critiques existing power dynamics and emphasizes the importance of amplifying marginalized voices, played a critical role in shaping the study's approach to data collection and analysis (Smith et al., 2009). In formulating the interview questions, feminist principles guided the inclusion of queries that explicitly sought to capture gender-specific experiences and the impact of societal norms on participants' diagnostic journeys. For example, questions were designed to explore how participants perceived gender expectations influencing their ADHD symptoms and their interactions with healthcare providers, ensuring that the study foregrounds the voices and experiences of women (Herron, 2023; Matsick et al., 2021). This alignment between theory and methodology ensures that the study not only documents but also critically analyzes and explores the gendered dimensions of ADHD diagnosis.

Critical disability theory further enriches the methodological approach by challenging the deficit-based narratives that often dominate discussions of ADHD. This theory emphasizes the importance of understanding disability as a socially constructed phenomenon, shaped by societal attitudes and systemic barriers rather than inherent deficits (Goodley, 2014). In this study, critical disability theory informs the IPA approach by guiding the interpretation of data through a lens

that seeks to uncover how systemic ableism and societal perceptions of disability impact the diagnostic experiences of women with ADHD.

By explicitly connecting these theoretical frameworks with the IPA methodology, the study ensures a coherent and rigorous approach that not only captures the lived experiences of participants but also situates these experiences within broader social and systemic contexts. This methodological alignment strengthens the study's capacity to generate insights that are both deeply personal and broadly applicable, advocating for changes in diagnostic practices that reflect a more inclusive understanding of ADHD. As Smith et al. (2009) highlight, the strength of IPA lies in its ability to reveal the complexity of lived experiences, making it a fitting choice for research grounded in feminist and critical disability theories.

Ultimately, this integration of theory and methodology underscores the study's commitment to not only exploring the diagnostic experiences of women with ADHD but also to challenging and transforming the diagnostic process itself. By drawing on feminist and critical disability theories, the study aims to highlight the need for a diagnostic approach that respects and values the diverse manifestations of ADHD, promoting a more equitable and person-centered diagnostic landscape in Canada.

Aims

The study aims to investigate the unique experiences of women diagnosed with ADHD in Canada. Additionally, it seeks to collect recommendations from women to enhance the current ADHD diagnostic process in Canada. This research focuses on people who identify as women and were diagnosed with ADHD after turning 18.

Research Questions

1.) How does the current diagnostic process in Canada impact adult women diagnosed with ADHD?

2.) What specific recommendations do women diagnosed with ADHD in Canada have for researchers and healthcare professionals to enhance the current diagnostic process?

Methods

Philosophical Paradigm

This study utilizes a pragmatic paradigm to explore the current diagnostic process for women with ADHD in Canada. Many researchers and philosophers such as Kadlec (2016) and Morgan (2014) have explored the use of pragmatic in social research. The foundation of pragmatism as described by John Dewy in 1925 is to use the power of lived experience to inform critical reflection of society to create real progress toward improving the human condition (Kadlec, 2006). Inherently pragmatism has aspects of emancipatory and critical theory embedded into the paradigm through the use of lived experiences and societal examinations. These aspects of pragmatism can be seen in this study though the use of lived experiences of women with ADHD in Canada to critique the current diagnostic system. Where pragmatism strays from other paradigms such as the transformative paradigm is its theoretical requirement to create possible actions as a reaction to the problem (Morgan, 2014). While collecting the lived experiences of women with ADHD in Canada is an important and integral part of this study, the other aim is to collect recommendations to adapt the current process from these women that fosters potential actions to better the diagnostic process for women with ADHD in Canada.

Positionality Statement

Keeping in line with the study's critical pragmatic paradigm a researcher must accept two claims about human nature. One, human experiences are constricted by the nature of the world and our understanding and interpretation of the world are limited by our interpretations of our experiences (Morgan, 2014). Consequently it is important as the primary researcher to examine how my interpretation of my experiences of the world. With this in mind, I, as the primary researcher, am a woman who was diagnosed with ADHD in Canada in my early 20s. I have firsthand experience with multiple systemic barriers stemming from the shortcomings of the current ADHD diagnostic system. My passion and commitment to the topic were born out of these experiences, which supported my desire to create this study. While I believe it is important to acknowledge my personal experiences, I also believe firmly believe in the importance of supporting others to share their voices. I recognize as someone who has been impacted by the failures of the current system, I am biased. However, I have made efforts to ensure that I am collecting the authentic voices of the participants. These efforts include the IPA methodology which utilizes direct quotes from the interviews to ensure the authenticity of the results. The interview questions themselves were adapted from a peer reviewed study from Young et al. (2008) which examined the diagnosis process of ADHD in England. The questions were adaptive to fit the aims of the study and fit within the conceptual frameworks of the study. These questions were reviewed by fellow researchers to ensure their ability to capture authentic responses from participants and limit bias. It is important to note that due to my own personal experiences within the current diagnostic system and the framework I have chosen it is theoretically impossible to completely remove bias from the research. While I have taken steps

to ensure the authentic voice of the participants are displayed, my own experiences prompted me to study this topic and inherently affected the development of this study.

Methodology

This study used qualitative research methodology, through structured interviews as its data collection method. The rationale behind choosing a qualitative approach is to gather in-depth insights into the individual perceptions of women's experiences with the ADHD diagnostic process in Canada. The emphasis is on empowering and elevating each participant's unique experiences and perspectives. Rather than seeking generalized information about the broader process of ADHD diagnosis in Canada, the aim is to capture the diverse and personal narratives of the participants.

Participants

This study included four individuals who, at the time of their diagnosis, identified as women and were diagnosed by a healthcare professional in Canada at the age of 18 or older.

As this study employs a feminist perspective to examine the current ADHD diagnostic process in Canada, it becomes imperative to clarify and explore the term 'women' within the context of this research. Although inclusive transgender research is still in its early stages, a 2022 systematic review by Goetz and Adams encompassed 17 distinct articles that suggested that an individual's ADHD symptomology aligns with their self-identified gender, regardless of their assigned birth sex. For the purposes of this study, participants must have self-identified as a 'woman' or female at the time of their ADHD diagnosis. This criterion ensures that the research is centered on the diagnostic experience of individuals who identify as female while also acknowledging the complexity and duality of gender.

The decision to restrict the participant pool to individuals diagnosed at the age of 18 or older stems from findings in previous research. A study conducted by Kessler et al. (2006) demonstrated that there is a higher prevalence of adult ADHD diagnoses in women compared to female childhood ADHD diagnoses. Additionally, the work of Quinn and Madhoo (2014) sheds light on the adverse consequences of late (adult) ADHD diagnosis among women, which includes heightened levels of anxiety and depression. In the absence of an ADHD diagnosis, women often face prolonged struggles with inattentiveness, impulsivity, and emotional dysregulation without understanding the root cause of their difficulties. This can lead to persistent self-blame and frustration, which exacerbate anxiety and depression over time (Quinn & Madhoo, 2014). Additionally, lacking a diagnosis deprives them of targeted interventions and coping strategies, resulting in prolonged feelings of inadequacy and failure as they attempt to navigate critical life stages (Kessler et al., 2006). Kessler et al.'s (2006) identification of the trend wherein women often receive ADHD diagnoses later in life underscores the significance of this study. Through examining the consequences of navigating critical developmental stages without the awareness of ADHD, this research aims to collect valuable insights into this unique and understudied experience.

Recognizing the diversity of healthcare systems and cultural contexts across nations, this study uniquely focuses on the Canadian landscape. In reviewing hundreds of articles the diagnostic process of ADHD, I found very few that addressed the Canadian context. Out of the 42 references used in this study, only one specifically examines ADHD diagnostic experiences within Canada (Espinet et al., 2022). This limited representation underscores a significant gap in the literature and raises questions about the relevance of international findings to the Canadian healthcare system. Given Canada’s unique healthcare structure—marked by public funding,

limited access to specialists, and geographic challenges affecting service availability—there is a critical need for research that directly reflects the Canadian experience. Expanding this body of knowledge is essential to developing diagnostic practices that respond to the specific systemic barriers Canadian women with ADHD face.

Finally, the study's objective of including four participants is deliberate. This sample size was chosen to ensure that each participant's individual voice and experience could be authentically represented and thoroughly analyzed, aligning with the principles of Interpretative Phenomenological Analysis (IPA). IPA studies typically prioritize depth of analysis over breadth, focusing on small, purposive samples to allow for an in-depth exploration of each participant's unique perspective (Smith, Flowers, & Larkin, 2009). Smith et al. (2009) suggest that sample sizes between three and six participants are generally sufficient for a master's-level IPA study, as this allows the researcher to conduct a detailed, nuanced analysis without overwhelming the interpretative process. Additionally, given the time and resource constraints inherent in completing a master's thesis, a sample size of four participants was manageable within the scope of this research while still allowing for a rigorous, meaningful exploration of the ADHD diagnostic process for women

Recruitment Process

Participants for this study were recruited through online social media advertisements. Virtual posters were disseminated across various online support groups dedicated to adults living with ADHD. These support groups are publicly accessible on different social media platforms, including Facebook™ and TikTok™. It is essential to note that as the investigator I am an active member of these online groups. Prior to posting virtual posters in these support groups, formal permission was sought from the administrators of each group. Furthermore, each virtual poster

included a written description to ensure accessibility for all potential participants. Recruitment procedures, including the use of social media groups and online advertising, were reviewed and approved by the Research Ethics Board (REB) to ensure adherence to ethical standards and participant safety.

To facilitate communication, all recruitment materials directed potential participants to contact a secure email address for further information and inquiries. Prospective participants who expressed interest received comprehensive details about the study and were provided with consent forms to be completed and signed before scheduling a Zoom™ interview. Participants retained the autonomy to discontinue their involvement at any point—before, during, or after the interview—by emailing the primary investigator to express their desire to withdraw. No participants withdrew from the study.

Measures

This study sought to explore the unique experiences of late-diagnosed adult women with ADHD in Canada by examining and reflecting upon their diagnostic journeys. A key aim was to genuinely capture and amplify the voices of participants, using a structured interview format adapted from a 2008 study by Young and colleagues (see Appendix B). The structured format included a set of open-ended questions designed to guide participants through their diagnostic experiences, focusing specifically on the emotional, social, and systemic aspects of their ADHD journey. Questions were adapted to probe themes such as the initial recognition of ADHD symptoms, interactions with healthcare providers, and the personal impact of a late diagnosis. These adaptations specifically refocused the interview on the diagnostic process, placing less emphasis on medication-related effects. Additionally, changes were made to eliminate ableist

language, replacing terms like 'difficulties' with language that emphasizes the structural and societal barriers individuals with ADHD encounter in an ableist society.

In alignment with Schalk's (2013) insights from critical disability studies, the term 'impairment' was intentionally reframed within the interview to avoid connotations of personal deficit. Instead, 'impairment' was presented as a neutral aspect of participants' experiences, with an emphasis on how societal structures—not individual limitations—often create barriers to full participation. This reframing is based on the idea that ADHD, like other neurodivergent conditions, is not inherently negative but is often perceived as such due to rigid societal standards and lack of accessibility. By addressing ADHD symptoms as features rather than flaws, the study aimed to create an interview environment that affirmed participants' identities and centered on the external factors impacting their experiences, rather than implying that their ADHD traits themselves were problematic.

The interviews were conducted via Zoom, chosen for its capacity to overcome numerous accessibility and distance-related barriers commonly encountered during in-person interviews. Online platforms like Zoom allow researchers to reach participants who may face geographical, physical, or time constraints, thereby enhancing accessibility (Archibald et al., 2019). These interviews were recorded and subsequently transcribed, facilitating in-depth analysis during the study's analysis phase.

Procedure

1. Participants initially accessed the recruitment materials via social media platforms. Once interested, participants were instructed to contact the secure Brock University email address provided in the recruitment materials, expressing their desire to participate in the study.

2. Upon receipt of their email, participants received a response from the primary investigator, including comprehensive information about the study, participant requirements, and the necessary consent forms (See Appendix A). Participants were expected to complete these consent forms and return them via email to the primary investigator.
3. Following the primary student investigator's review of the consent forms, the participant was contacted again via email. They were asked to indicate their preferred availability for a Zoom™ interview. Once a suitable time was determined, the participant received a calendar invite for the scheduled interview.
4. The interview itself took place over Zoom™ and lasted approximately 60 minutes. Upon completion of the interview, participants were not required to take any further action. Participants received a copy of their transcript and/or the final research paper via email as a follow-up if requested.

Analysis

In alignment with Young et al. (2008), this study employed Interpretative Phenomenological Analysis (IPA) as the method for analyzing interview data (Smith, Flowers, & Larkin, 1999). Each interview transcript was printed to facilitate direct notetaking by the researcher, enhancing comparability across individual transcripts and allowing for a thorough, iterative analysis process (Smith et al., 1999). Following the structured steps of IPA analysis outlined by both Young et al. (2008) and Smith, Flowers, and Larkin (1999), the initial phase involved reading each transcript carefully, I used a blue pen to record primary and noteworthy ideas. In a second review of each transcript, keywords and key phrases were documented in red pen to distinguish emergent themes.

This systematic process was applied consistently across all interviews, generating a comprehensive list of themes. I then cross-referenced these themes across the interviews, identifying consistencies and interconnections that pointed to broader patterns in participants' experiences (Young et al., 2008; Smith et al., 1999). Common themes were subsequently grouped into primary and secondary categories. For instance, **Self-Blame**, **Systemic Ableism**, and **Misogyny** emerged as primary themes due to their frequent and significant impact across participants' narratives. These themes captured the overarching struggles and systemic barriers that shaped participants' experiences with ADHD diagnosis. In contrast, themes like **Hitting a Breaking Point**, **The Importance of Community**, **Grief**, and **Self-Acceptance** were considered secondary themes, as they represented specific, though impactful, aspects of participants' journeys that connected back to the primary themes. Every transcript was revisited to ensure that these themes accurately reflected the original content, with key phrases and keywords included in the results to authentically represent participants' voices and perspectives, reinforcing the IPA's commitment to capturing lived experiences in depth (Smith et al., 1999; Young et al., 2008).

As IPA recognizes the impact that the researcher has as an active participant in the research project my reflections of the data as the primary researcher were included in the analysis. My reflections were examined with the use of my research journal that was used throughout the interview and analysis process. The research journal explored my thoughts, emotions, and initial reactions during the development, interview, and analysis stages.

Results

Demographics of Participants

The participants in this study provide diverse insights into the impact of the ADHD diagnostic process on women, highlighting how individual backgrounds shape their experiences and align with the broader themes identified in this research.

Participant A was 27 years of age at the time of the interview for this study. Participant A was 24 years old and living in rural Ontario at the time their diagnosis. Participant A grew up in a rural community with limited access to specialized healthcare, which she felt delayed her ADHD diagnosis. She excelled in certain academic subjects but struggled with everyday tasks that she felt others managed effortlessly. These challenges underscore the barriers faced by people in similar communities where support services are scarce. Like Participant A, I experienced the challenges of growing up in a small town with limited healthcare access and faced similar dismissals of symptoms that didn't align with traditional diagnostic criteria. This shared experience highlights the importance of a reflexive approach that acknowledges how personal experiences intersect with academic analysis.

Participant B was 38 years of age at the time of the interview and 35 at the time of their diagnosis. The participant resided in a large metropolitan area in Ontario during their diagnosis. Despite facing significant academic barriers, Participant B pursued higher education and relocated internationally to Canada (originally living in Australia). Her inattentiveness and inconsistent academic performance were often misunderstood as a lack of effort rather than ADHD symptoms. I see parallels between Participant B's story and my own, particularly in how systemic neglect of ADHD in women delayed recognition and support. Her experience illustrates

broader issues where educational and professional contexts often misinterpret the struggles of women with ADHD, reinforcing the need for more inclusive diagnostic practices.

Participant C was 33 years of age at the time of the interview and was 28 at the time of their diagnosis. The participant was living in a suburban setting in Nova Scotia i when diagnosed. Participant C frequently felt different from her neurotypical peers and initially attributed her struggles to familial circumstances rather than neurodiversity. She and others misidentified her ADHD symptoms as depression and bipolar disorder, reflecting a common diagnostic challenge for women, as discussed in the literature (Young et al., 2020). Participant C's narrative of misattribution resonates with my own experience of navigating misdiagnosis due to inattentive presentations of ADHD in women. This commonality highlights the critical need for diagnostic criteria that adequately reflect the diverse manifestations of ADHD, particularly in females.

Participant D was 36 years old at the time of the interview and 33 at the time of her diagnosis. She was living in a rural community in British Columbia during her diagnostic process. Participant D recognized her differences early on but faced dismissal from both her family and the healthcare system. Her academic success often masked her symptoms, which were frequently attributed to personality traits rather than recognized as indicators of ADHD. This aligns with findings in the literature that 'high functioning' women are frequently overlooked in ADHD assessments (Quinn & Madhoo, 2014). Among the participants, only one had a formal diagnosis of depression as a comorbid condition, while the others had their ADHD symptoms initially misinterpreted as anxiety or depression, rather than being accurately identified. Reflecting on Participant D's story, I see parallels with my own experiences of systemic ableism and misogyny, where both personal and systemic dismissals hindered

recognition of my ADHD. Her narrative reinforces the need for diagnostic frameworks that capture the full spectrum of ADHD presentations in women."

Participant Engagement

Participant engagement in this study was remarkable, underscoring the importance and relevance of this research. Every participant requested a copy of the finished study, eager to see their experiences contribute to a broader understanding of ADHD in women. Additionally, all participants asked to review their interview transcripts and took considerable time to read through them, responding thoughtfully to confirm that their voices and experiences were accurately captured. All participants also took time at the end of their interviews to thank me, expressing how meaningful it felt to openly discuss these challenges and participate in a study that addressed gaps in ADHD diagnosis for women. The level of interest was further evident in the more than 20 inquiries I received from others wishing to participate, despite no compensation being offered. This response reflects not only the need for research in this area but also a collective desire among women with ADHD to be seen, heard, and accurately represented.

Themes

In my view, the analysis of the interviews with the four participants highlighted three primary themes: Self-Blame, Systemic Ableism, and Misogyny, along with four secondary themes: Hitting a Breaking Point, The Importance and Suggestions of Community Resources, Grief, and Self-Acceptance. My analytic process was primarily inductive, as I approached the data without predetermined categories and allowed themes to emerge organically from participants' narratives. However, my choice of terms, such as systemic ableism and misogyny, was influenced by the study's feminist and critical disability frameworks, which shaped how I interpreted and labeled the data. For example, while participants often spoke about feeling

personally responsible for their struggles, I interpreted these accounts through a lens of internalized oppression and identified Self-Blame as a theme that reflects both personal and systemic factors.

In developing these themes, I maintained an active role in connecting participants' personal reflections to broader social structures, as informed by feminist and critical disability perspectives. Terms like Systemic Ableism and Misogyny were used to capture recurring patterns of institutional bias and gendered dismissal described in participants' stories, aligning these experiences with critical concepts relevant to ADHD and gender. Conversely, themes like Self-Blame emerged directly from participants' language, capturing the internalized pressures they felt to conform to societal expectations. Through this blend of inductive theme generation and interpretive alignment with theoretical frameworks, I believe these primary and secondary themes effectively capture the multifaceted and deeply personal experiences of women diagnosed with ADHD in adulthood in Canada.

Primary Themes

Self-Blame

Throughout their childhood and adolescence, participants acknowledged a pervasive sense of self-blame and feeling different from their peers and family members. This feeling developed from being repeatedly told by others, including family members, friends, and teachers, that they were "problem children" and that there was something inherently wrong with them. For example, Participant C recounted, "I just thought I was kind of dumb. I knew a lot of trivia, but I just thought I was kind of stupid and lazy." Similarly, Participant A recalled being told, "My parents were convinced I was just being arrogant and stupid." This negative feedback was a regular occurrence, leading participants to internalize these labels: "I was told more or less daily

that it was just naughtiness, being disruptive purely out of seeking attention," shared Participant D.

Moreover, all participants recognized the immense effort they exerted to meet societal standards and the toll this took on their self-worth. Participant B expressed, 'I felt I had to work ten times harder because my brain worked differently.' This statement reflects a common experience: the relentless drive to conform and the accompanying sense of inadequacy when those efforts fell short. Personally, I too felt this constant pressure to keep up, only to face disappointment and self-doubt when I couldn't meet expectations. This theme of self-blame, then, is not merely about individual struggles but points to the broader systemic issues that fail to acknowledge and support neurodiverse individuals. Research indicates that women with ADHD, especially those who do not fit the typical hyperactive or impulsive ADHD profile often associated with men, frequently find themselves misunderstood or overlooked in clinical settings (Quinn & Madhoo, 2014; Young et al., 2008).

In many cases, women encounter a healthcare and educational system that continues to rely on stereotypical ADHD presentations, leaving those with less visible or more internalized symptoms without the validation and support they need (Nussbaum, 2012). This oversight in diagnostic and support systems perpetuates a cycle where neurodiverse individuals feel compelled to work beyond their limits to 'fit in,' leading to exhaustion, low self-esteem, and mental health struggles (Mowlem et al., 2019). Without frameworks that fully recognize and accommodate diverse cognitive experiences, the system inadvertently places the burden of adaptation solely on the individual, reinforcing feelings of inadequacy. For these participants, the realization of their ADHD diagnosis later in life illuminated these systemic shortcomings,

highlighting the urgent need for more inclusive and nuanced diagnostic criteria and support systems that validate a wider range of ADHD presentations (Goodley, 2014; Schalk, 2013).

Systemic Ableism

Systemic ableism emerged as a significant theme across all interviews that, deeply affected participants' experiences in educational, personal, and professional settings. Participants described environments that were not accommodating to their needs, reinforcing feelings of inadequacy and exclusion. In Nova Scotia, Participant C recounted, “If a child is diagnosed with a disability, they are often pulled out of French immersion programs because the school board has not invested the resources to support students with disabilities in these settings.” This practice not only limits the educational opportunities available to these children but also reinforces the notion that they are not capable of succeeding in more challenging academic environments. Participant C also mentioned that due to this practice, parents were resistant to get their children the supports they needed due to the fear of them being pulled out of school. This lack of resources and support further alienates these students and perpetuates a cycle of exclusion and diminished expectations.

Moreover, all participants recognized the immense effort they exerted to meet societal standards and the toll this took on their self-worth. Participant B expressed, 'I felt I had to work ten times harder because my brain worked differently.' This sentiment reflects a common experience: the relentless drive to conform and the accompanying sense of inadequacy when those efforts fell short. Personally, I too felt this pressure to keep up, only to face disappointment and self-doubt when I couldn't meet expectations. This theme of self-blame is not merely about individual struggles but highlights broader systemic issues that fail to acknowledge and support neurodiverse individuals, particularly women with ADHD who often do not fit the typical,

hyperactive ADHD profile commonly associated with men (Quinn & Madhoo, 2014; Young et al., 2008).

"Participants also discussed the broader issue of not being perceived as 'disabled enough' to warrant support. This concept was underscored by multiple experiences in which their struggles were minimized or dismissed because they did not fit the stereotypical image of ADHD. For instance, Participant A recounted being told, 'You can't have ADHD; you're smart,' while Participant D faced pushback when seeking a diagnosis: 'The doctor just said, "You are smart, you're in your master's. Maybe you should just get your hearing checked."' These examples underscore how systemic ableism often manifests as gatekeeping, where individuals are denied recognition and support simply because they do not conform to narrow definitions of ADHD or disability. Such gatekeeping in healthcare and educational settings perpetuates a cycle of self-blame and inadequacy, leaving individuals feeling that they must prove their struggles to access help (Nussbaum, 2012; Mowlem et al., 2019). Without frameworks that fully recognize and accommodate diverse cognitive experiences, the system often places the burden of adaptation solely on individuals, reinforcing feelings of inadequacy. For these participants, receiving an ADHD diagnosis later in life revealed these systemic shortcomings and highlighted the pressing need for more inclusive and nuanced diagnostic criteria that validate a broader range of ADHD presentations (Goodley, 2014; Schalk, 2013).

These systemic barriers extended into professional environments as well. Participants described how their symptoms were often overlooked or misunderstood by employers and colleagues. Participant B recounted her struggles in the workplace: "I'm late to work every morning, and I've almost lost my job over this. It's getting in the way of my relationships because I was asked to do something, and I was like I can't remember." This lack of understanding and

accommodation in professional settings further exacerbated their difficulties and reinforced the internalized belief that their challenges were due to personal failings rather than a lack of systemic support. Reflecting on these narratives, I am reminded of my own educational experiences where my ADHD symptoms were misinterpreted as a lack of discipline or commitment, rather than a legitimate need for accommodations.

Systemic ableism also deeply affected participants on a personal level, particularly within their family relationships. Participants described how their struggles with ADHD were often misunderstood or minimized by family members, who tended to attribute their challenges to personal failings rather than legitimate needs. For instance, Participant A shared, 'My parents were convinced I was just being arrogant and stupid,' leading to feelings of isolation and frustration. This response from her family reflects a broader societal narrative in which ADHD-related challenges are often perceived as issues of character or commitment, rather than as neurodivergent needs that require understanding and support.

Additionally, the lack of awareness and understanding about ADHD within families often meant that participants grew up without the accommodations or empathy they needed. Participant D described how her family avoided discussing ADHD throughout her childhood and into adulthood, despite her belief that her father likely had the condition as well: 'My family didn’t talk about the fact I have ADHD because my dad probably has it, and we all know it’s a genetic thing. Feelings are not something we talk about in my family.' This generational reluctance to address ADHD reflects a cultural silence around disability, where acknowledgment of neurodivergent needs is absent. This silence left Participant D without the support or understanding necessary to make sense of her experiences, contributing to feelings of self-blame and isolation as she struggled to meet unspoken expectations.

In my own experience, family dynamics regarding ADHD echoed these struggles, where societal beliefs about disability were internalized and perpetuated within close relationships. These beliefs not only impact the emotional well-being of neurodivergent family members but also create barriers to timely diagnosis and effective support. Participants' experiences highlight that systemic ableism extends beyond institutional settings, infiltrating personal relationships and reinforcing negative beliefs about disability. This interpersonal manifestation of ableism compounds the barriers faced by people with ADHD, who may struggle to find validation or acknowledgment in their closest relationships, ultimately delaying diagnosis and access to appropriate accommodations.

Misogyny

Misogyny—defined as the systemic discrimination and prejudice against women, often manifesting as the devaluation or dismissal of women's experiences—significantly impacted the participants' experiences with the diagnostic process (Tileagă, 2019). This form of bias is well-documented in healthcare, where women's symptoms are frequently misunderstood or minimized due to gendered expectations (Ussher, 2013). For example, Participant B shared, 'Gendered expectations often led to me being labeled as lazy or unmotivated rather than receiving a proper evaluation for ADHD.' This experience was common among the participants, who noted that their symptoms were often treated as personal failings rather than as indicators of ADHD. Multiple participants, including Participant C, observed that their male peers or family members were often seen as 'gifted,' while they were perceived as weak students despite exhibiting similar behaviors, such as turning in work late or completing tasks quickly. This disparity underscores how deep-seated misogyny in our culture affects perceptions of ADHD symptoms, leading to biases that disproportionately disadvantage women in receiving accurate diagnoses.

The participant's stories resonate with my own experiences in academic settings, where my male peers were praised for their attentiveness to detail in group projects, while I was labeled as bossy or rude for the same behaviors. It was frustrating not only because my symptoms of ADHD were overlooked, but also because my strengths—such as attention to detail—were dismissed as negative traits simply because they did not align with the expectation that women should be polite and accommodating. This disconnect between perception and reality reflects a broader societal issue where gender norms obscure the true nature of ADHD in women.

Moreover, participants described how societal expectations of women further complicated their experiences with ADHD. Participant C noted, "I think because I present very inattentive in the female sense where I'm not like zoned out. I was like inattentive because I'm reading a book, and I can't tear myself away from this book. So, no one was like, 'Oh, well, she's just a bookworm.'" This comment again underscores how female-presenting symptoms are often dismissed as personal traits rather than recognized as ADHD, influenced by societal perceptions around the disorder. Another participant, Participant D, highlighted the impact of gender biases on the diagnostic process, stating, "I think the biggest barrier is that ADHD is seen as a bad thing. It's more acceptable for boys to be hyperactive, but for girls, it's like, 'Why can't you just sit still and be quiet?'" These societal expectations for girls to conform to certain behaviours often led to the perception that their symptoms of ADHD were personal failures, which in turn further delayed their diagnosis and compounded the barriers they faced

Reflecting on these narratives, I recognize a shift in my own thinking after receiving my diagnosis. I realized that the traits I had been told were negative—like being assertive or highly focused on details—were actually strengths stemming from my ADHD. It was a pivotal moment in understanding that what had been framed as deficits were, in reality, attributes that I could

harness. This shift parallels the journeys of the participants, who also navigated a reframing of their self-perception in light of their ADHD diagnosis.

Secondary Themes

Hitting a Breaking Point

All participants described reaching a critical breaking point that prompted them to seek a diagnosis. Despite clearly struggling with undiagnosed ADHD for years, it was often a culmination of unmanageable stress, emotional dysregulation, or significant life changes that drove them to finally seek help. This breaking point was frequently reached during their time in college or university, where the increased demands of higher education exacerbated their struggles. The transition to higher education often meant increased responsibilities and less external structure, which intensified the symptoms of ADHD. Participants found themselves struggling to keep up with the workload, manage their time effectively, and meet academic expectations. This added pressure often led to feelings of inadequacy and failure, further pushing them toward seeking a diagnosis.

Participant A described her breaking point during her university studies, where the overwhelming academic pressure and lack of support led her to seek a diagnosis: "I didn’t really have any coping mechanisms because I don't think I ever really thought I had ADHD until I was in the education program. When we were studying universal differences, and they brought up the universal ADHD checklist." The realization that the barriers she faced were not due to personal failings but an underlying condition, prompted her to seek help. This realization mirrored my own, as I, too, reached a point where the academic demands became unmanageable, forcing me to confront the true nature of my struggles.

Similarly, Participant B reached her breaking point while navigating the demands of college: "When I was in college in my first semester, I went to the campus doctor and was like something's wrong with me. I don't know what it is. I'm tired all the time. I can't get up in the mornings to go to class." The intense stress and inability to manage her workload led her to suspect that she might have ADHD and seek a diagnosis. Participant C also faced significant challenges during her time at university, which contributed to her breaking point. She described how her inability to keep up with academic demands made her feel inadequate and overwhelmed: "I didn't go to college right after high school because I was like, well, my grades are kind of good enough, but I also don't think at the time I was like, well, I don't think I could do more school. I thought I couldn't keep up." This self-doubt and the stress of attempting to manage her responsibilities without understanding the root cause of her difficulties led her to seek a diagnosis.

For Participant D, the breaking point came with the added stress of the COVID-19 pandemic and personal losses: "Around 2021 I suspected. Okay. Wasn't until like 2022 it kind of hit a really low like I basically had a really rough period of like panic attacks. I basically like went to my boss and was like I need to take short term. Just I just wasn't functioning very well. And then after that I said I kind of really rethought it." The convergence of professional pressures, personal grief, and the pandemic created an unmanageable situation that forced her to seek a diagnosis. This narrative resonates with the broader experience of hitting a low point where the usual coping strategies no longer suffice, a familiar turning point in the ADHD diagnostic journey.

These breaking points were pivotal moments that helped guide the participants' journey toward understanding and managing their ADHD. The intense stress and overwhelming demands

of higher education and life circumstances played a significant role in bringing their struggles to the forefront, prompting them to seek the help and support they needed. The common thread among participants was being in a stressful environment that exasperated their symptoms to the point that made it impossible to continue living without addressing their ADHD symptoms. This realization was a turning point that forced them to seek help and begin to manage their symptoms, reflecting the shared and deeply personal journey of recognizing ADHD not as a personal failing but accepting that their brain just works differently.

The Importance and Suggestions of Community Resources

Community resources played a vital role in participants' journeys toward understanding and seeking a diagnosis for ADHD. These resources provided validation, information, and support that were often lacking in traditional medical settings. Accessing community resources gave participants the courage and knowledge needed to pursue a diagnosis, filling critical gaps in the healthcare system.

For all participants, reaching a breaking point led them to undertake significant self-directed research to better understand their symptoms. This added yet another layer of labor to their already overwhelming experiences. Participants often turned to online communities, particularly on platforms like TikTok™, to gather information and validate their struggles. Participant B explained, "TikTok is what gave me the little breadcrumbs. It helped me understand what it meant and potentially the diagnosis journey." Another participant described the effort required to prepare for her doctor’s visit, stating, "I kind of came in with a list of likes, 'I do this. I do this. I do this. It's getting in my way.'" This proactive approach became necessary because participants often encountered skepticism and dismissiveness from healthcare professionals, a barrier I also experienced in my own path to diagnosis.

These online communities provided not only information but also emotional support, helping participants feel less alone. One participant emphasized the supportive role of platforms like TikTok™, where shared experiences fostered a sense of belonging and encouraged her to pursue a formal diagnosis. This communal validation was instrumental in helping participants realize that their struggles were not isolated incidents but shared experiences, and that seeking a diagnosis was a positive step.

This study itself underscores the vital role of community resources, as it was recruited via social media. The overwhelming outpour of support and interest in the study highlights how these platforms serve as powerful tools for connection and engagement within the ADHD community. The response not only reflects the high demand for research in this area but also emphasizes the effectiveness of community-driven resources in reaching and supporting individuals who may feel isolated or misunderstood by conventional avenues. This level of engagement underscores the transformative power of community resources in providing both practical and emotional support for individuals with ADHD, demonstrating their indispensable role in the broader ADHD landscape.

Participants also emphasized the need for more accessible and understandable diagnostic tools. Two participants suggested that resources explaining the intent behind diagnostic questions would significantly support people filling out the surveys through the diagnostic process. For instance, instead of simply asking, 'Do you often feel restless?' an explanation could clarify that restlessness may manifest as difficulty sitting still, frequent fidgeting, or a constant need to change tasks. Additionally, defining 'often' could help individuals by specifying that it refers to experiencing restlessness on most days or at multiple points throughout the day. This context

would enable individuals to more accurately reflect on their experiences, helping healthcare providers understand their symptoms in a way that aligns with diagnostic criteria.

Additionally, participants expressed the need for better support systems within educational institutions. One participant stressed the importance of creating inclusive checklists and criteria that reflect the diverse presentations of ADHD, particularly in women. These presentations may include inattentiveness (such as difficulty maintaining focus or forgetting details), hyperfocus on specific interests, internalized hyperactivity (such as restlessness, fidgeting, or a feeling of internal tension), emotional sensitivity, heightened anxiety in response to stress, chronic procrastination, perfectionism, and difficulty with time management and organization. Such symptoms might also appear as avoidance of tasks perceived as overwhelming, challenges with prioritizing responsibilities, or an intense emotional response to perceived failures. She advocated for resources and accommodations tailored to students with ADHD to help them navigate their academic challenges more effectively, recognizing that these varied expressions of ADHD may otherwise go unnoticed or be misunderstood by educators.

"The participants recommendations to support women through the diagnostic process are as follows:

Detailed Explanations: Providing clear explanations of what each diagnostic question aims to uncover and how it relates to ADHD symptoms. Participants felt like some questions they were asked were confusing and were not clear as to what they were being asked.

Examples and Context: Offering examples that help women relate their personal experiences to the symptoms described in diagnostic criteria. Some of the participants felt

that they needed to provided context to answer questions which is not possible to provide when completing questionaries.

Peer Support Networks: Facilitating connections with others who have gone through similar experiences to provide emotional support and practical advice.

Educational Resources: Creating materials that educate both individuals, educators, health care providers and the wider public about ADHD in women, reducing stigma and increasing understanding.

Advocacy Tools: Creating tools that equip women with strategies and tools to effectively communicate their symptoms and challenges to healthcare providers. Also providing healthcare providers with education that encourages listening and validating women's concerns.

The recommendations that the participants gave showcase that community resources serve as a lifeline, particularly for those who have felt marginalized or overlooked within traditional healthcare settings. They offer a space where the voices and experiences of individuals with ADHD are heard, validated, and valued, reinforcing the critical need for inclusive, accessible, and community-oriented support structures in the ADHD diagnostic process

Grief

Grief emerged as a significant theme among participants, as they reflected on their past struggles and the impact of a delayed ADHD diagnosis. Many participants expressed a deep sense of loss and regret over the years spent feeling inadequate, misunderstood, or incapable of meeting their potential. This grief was not only about missed opportunities but also about the emotional toll of navigating life without understanding the root cause of their struggles.

Participant C shared, 'I went through a period of mourning the loss of myself that I could have been. Had I gotten a diagnosis in high school, maybe I would have done better.' This sentiment of wondering what might have been echoed by others who grappled with the weight of what they perceived as lost time.

Participants noted that an earlier diagnosis could have led to strategies and supports that might have changed their educational and personal experiences. Access to tailored learning strategies, such as tools for managing time and organization, may have helped them perform more confidently. Additionally, understanding their symptoms earlier on could have shifted their self-perception, allowing them to attribute struggles to ADHD rather than personal inadequacy. Instead of feeling 'lazy' or 'incapable,' they might have developed self-compassion and a clearer sense of self-worth, reframing their experiences as challenges related to ADHD rather than personal failings. This shift in attribution could have enabled them to think differently about their abilities and potential, building a stronger foundation of self-understanding and resilience. For many, having an accurate perception of their neurodivergence would have meant navigating life with a sense of validation and purpose, rather than enduring years of self-doubt and regret.

Similarly, Participant B described the sense of mourning her younger self: "I think about all the things I could have done differently if I had known. I spent so much time thinking I was just lazy or not trying hard enough." This reflection on the past highlights the emotional burden carried by many women with ADHD, who often internalize their struggles as personal failings rather than recognizing them as symptoms of an undiagnosed condition. For these participants, the diagnosis brought a complex mix of relief and grief—a relief in finally having an explanation and grief in realizing how long they had lived without one.

I deeply resonate with these feelings of grief, as I also have reflected on who I could have been if I had received a diagnosis earlier in life. Like the participants, I have wondered how my academic and personal journey might have unfolded differently had I understood my ADHD sooner. This shared experience of looking back and mourning the “what ifs” emphasizes the profound impact of delayed diagnosis, not just in terms of missed opportunities but also in the emotional and psychological cost of navigating life feeling perpetually out of sync.

Participant D also explained this sense of loss when she said, "It's hard not to think about all the times I struggled and how different things might have been. I can't help but feel angry sometimes about all the time I lost." This anger, mixed with sadness, underscores the complex emotions tied to recognizing ADHD later in life. It is not just about the past struggles, but also about coming to terms with a new understanding of oneself—a realization that, for many, comes with the weight of years spent compensating for a condition they never knew they had.

For many participants, this grief was compounded by the societal pressures and expectations they felt growing up. Participant A noted, "I feel like I missed out on so much because I was always just trying to keep my head above water. If I had known, maybe I wouldn't have felt so alone." The shared experience of feeling different and misunderstood, often for decades, connects deeply to the grief of realizing that so much of that pain could have been alleviated with earlier recognition and support.

Self-Acceptance

The journey toward self-acceptance was a common theme among participants, as they began to recognize ADHD not as a personal failing, but as an integral part of their identity that brought unique strengths. For many, receiving a diagnosis allowed them to reframe their past struggles, moving away from self-blame and toward a deeper understanding of their abilities and

limitations. Participant A expressed, "It made me hate myself less, honestly. I used to be so frustrated with myself all the time, but now I understand myself better." This shift in perspective helped her to appreciate her ADHD as a source of her creativity and resilience, rather than a hindrance.

Similarly, Participant C noted, "I used to see my differences as deficits, but now I can see how my ADHD makes me who I am. It's not all bad—I'm creative, I'm resourceful, and I think outside the box." This recognition of ADHD as a strength rather than a weakness was transformative for many participants. They described a newfound sense of pride in their unique ways of thinking and problem-solving, which had often been misunderstood or undervalued by others. This resonated deeply with me as well; understanding my ADHD allowed me to recognize that the barriers I faced were not a result of my shortcomings but rather the failure of others to see and accommodate my strengths.

Participant B echoed this sentiment, saying, "It’s like I’m finally giving myself a break. I’ve spent so long thinking I was just broken or not good enough, but now I know that I was just trying to navigate a world that wasn’t built for me." The diagnosis provided a framework for understanding that her struggles were not due to a lack of effort or ability, but rather systemic barriers and a lack of support. This realization was empowering, as it shifted the blame away from herself and onto the inadequacies of the systems around her.

Participant D reflected on how self-acceptance also involved challenging the stigma and negative perceptions surrounding ADHD: "People think ADHD is just about not being able to focus, but it's so much more. For me, it’s being able to hyper-focus on things I’m passionate about, and that’s a gift." This reframing of ADHD traits as valuable rather than problematic was a key part of the participants' journeys toward self-acceptance. They learned to see their

differences as attributes that set them apart in positive ways, rather than as flaws to be hidden or corrected.

I found myself resonating strongly with these reflections on self-acceptance. Like the participants, recognizing ADHD as a strength allowed me to move beyond the negative labels that had been imposed on me and to see my unique capabilities in a new light. Understanding that the barriers I faced were not a reflection of my own worth, but rather the result of external misunderstandings and systemic failings, was a powerful shift. This shared realization among participants underscores the importance of self-acceptance in the ADHD journey—not just as a means of personal empowerment, but as a necessary step toward challenging the broader societal narratives that often marginalize neurodiverse individuals.

Discussion

The findings of this study provide a nuanced understanding of the ADHD diagnostic process for women in Canada, highlighting the significant challenges and barriers they face. These results are contextualized within existing research and offer insights into the implications for future practice and policy (Quinn and Madhoo, 201.

Firstly, the theme of self-blame was prevalent among participants, who internalized negative labels and criticism throughout their lives. This finding aligns with previous research by Kessler et al. (2006), which found that women often receive ADHD diagnoses later in life, leading to prolonged periods of unrecognized struggles and self-blame. These results suggest that greater awareness and education about ADHD's diverse presentations could mitigate these feelings of inadequacy and promote earlier diagnosis and intervention.

Systemic ableism emerged as a significant barrier, particularly in educational and professional settings. In Nova Scotia, participants noted that children with disabilities are often

removed from French immersion programs due to insufficient resources. This practice limits opportunities and reinforces the notion that these students are less capable, echoing Goodley's (2014) discussion on how ableist structures perpetuate exclusion and diminished expectations.

Removing students from enriched programs highlights a broader issue in educational systems that prioritize normative standards over inclusivity. This exclusion can lead students with ADHD and other disabilities to internalize feelings of inadequacy, exacerbating symptoms of anxiety and depression (Mao & Findling, 2014). Participants shared that such systemic barriers also hindered their social integration and skill development, especially in bilingual contexts. Addressing these barriers requires policy changes and resource investment, such as teacher training on ADHD, access to specialized staff, and individualized education plans (IEPs) (Lauchlan & Greig, 2015). Additionally, universal design for learning (UDL) principles—multiple means of representation, engagement, and expression—would make learning more accessible for all students (Meyer, Rose, & Gordon, 2014).

Participants also emphasized that inclusive criteria reflecting diverse ADHD presentations, such as inattentiveness, internalized hyperactivity, emotional sensitivity, and time management challenges, would prevent students from being unfairly excluded. Similar issues persist in the workplace, were individuals with ADHD face misunderstandings and limited accommodations. These findings align with critical disability theory, advocating for systemic change to support neurodiverse individuals across all settings (Goodley, 2014)

The results illustrate how deeply misogyny impacts the ADHD diagnostic process for women, with participants sharing experiences of dismissive and invalidating interactions with healthcare professionals. These encounters often left participants feeling misunderstood and unsupported, echoing patterns observed in Lynch and Davison's (2022) findings, which show

how gender biases in healthcare can contribute to delayed or missed diagnoses for women. For example, participants in the study described instances where their symptoms were attributed to personality traits or emotional instability rather than recognized as ADHD indicators, reinforcing gendered stereotypes rather than acknowledging the legitimacy of their concerns.

These accounts from the results highlight the critical need for healthcare providers to receive training on gender-sensitive diagnostic criteria. An empathetic and validating approach, grounded in awareness of how ADHD can manifest differently in women—such as through inattentiveness, emotional regulation challenges, or perfectionism—could help mitigate the biases that participants repeatedly encountered. Addressing these issues at a systemic level would not only improve diagnostic accuracy but also foster a healthcare environment where women's experiences are acknowledged and validated, ensuring they receive the support they need in a timely manner.

Participants often reached a breaking point during their time in college or university, where the increased demands of higher education exacerbated their struggles. This finding aligns with research by Agnew-Blais et al. (2016), which highlights the persistence and emergence of ADHD symptoms in young adulthood and the critical role of educational stress in prompting diagnoses. The results suggest that creating supportive academic environments could help prevent these crises and promote better outcomes for women with ADHD. Implementing Universal Design for Learning (UDL) principles—such as offering multiple means of engagement, flexible assessment options, and diverse ways of accessing content—could make learning environments more inclusive for students with ADHD (Meyer, Rose, & Gordon, 2014). Additionally, supportive environments might include accessible accommodations, flexible deadlines, and mental health resources tailored specifically for ADHD (Lauchlan & Greig,

2015). Training faculty to recognize ADHD's diverse presentations and equipping academic advisors with knowledge on available resources could also foster an environment where students feel understood and validated. By incorporating UDL and other targeted interventions, educational institutions can alleviate academic pressures, reduce the risk of crisis points, and provide an inclusive atmosphere that supports long-term success for neurodiverse students.

Community resources played a crucial role in participants' journeys toward diagnosis and understanding their ADHD. Online communities, particularly on platforms like TikTok, provided validation, information, and support that were often lacking in traditional medical settings. Participants emphasized the need for accessible and understandable diagnostic tools, suggesting that resources explaining the intent behind diagnostic questions would significantly support women through the diagnostic process. This finding underscores the potential of peer-led interventions and online communities in providing much-needed validation and information.

Participants expressed a profound sense of grief upon receiving their diagnoses, reflecting on the years lost to untreated ADHD. This grief was intertwined with anger and sadness over missed opportunities and unnecessary struggles, echoing Mao and Findling's (2014) findings on the significant impact of late-diagnosed ADHD on mental health and quality of life. The study highlights the need for timely and accurate diagnoses to prevent such negative emotional outcomes and to support individuals in realizing their full potential.

Despite the barriers, receiving a diagnosis eventually led to a journey of self-acceptance for many participants. They began to understand their experiences through the lens of ADHD, which allowed for greater self-compassion and the development of effective coping strategies. Schrevel et al. (2016) also emphasize the importance of self-understanding and acceptance in

managing ADHD. The results suggest that self-acceptance can be facilitated through accurate diagnosis, access to supportive resources, and the development of personalized coping strategies.

The implications of these findings are significant for future research, policy, and practice. Current diagnostic criteria often fail to capture the diverse presentations of ADHD in women. Future research should focus on developing and validating gender-sensitive diagnostic tools that consider the full spectrum of ADHD symptoms. Healthcare systems should implement these updated criteria to ensure more accurate and timely diagnoses for women. Healthcare providers need specialized training to understand the gender-specific manifestations of ADHD. This includes recognizing inattentive symptoms and understanding the impact of societal expectations on women's experiences. Training programs should also address potential biases and encourage a more empathetic approach to diagnosing and supporting women with ADHD.

The results also highlight how online communities and peer support networks play a vital role in providing information and emotional support. These resources should be strengthened and made more accessible to women seeking validation and guidance. Developing comprehensive online resources that offer educational materials, diagnostic tools, and peer support can bridge gaps in traditional healthcare settings.

Systemic ableism and misogyny significantly hinder the diagnostic process. Policy changes and educational campaigns are needed to foster a more inclusive and supportive environment for women with ADHD. Institutions should implement practices that actively combat these biases, ensuring equal access to diagnosis and support for all individuals.

Developing resources that explain the intent behind diagnostic questions and provide relatable examples can help women articulate their experiences more effectively. This clarity is crucial in helping healthcare providers understand and diagnose ADHD accurately. Educational

materials should be created for both patients and providers to increase awareness and reduce stigma associated with ADHD.

The diagnostic process should prioritize the individual's experiences, needs, and preferences. Listening to and validating women's concerns is essential in creating a supportive diagnostic environment. Ensuring that women have access to clear explanations and supportive resources throughout the diagnostic journey can improve their overall experience and outcomes.

Ongoing research is necessary to further understand the unique experiences of women with ADHD and to develop effective diagnostic strategies. Advocacy efforts should aim to raise awareness and promote policy changes that support women with ADHD. Engaging with policymakers, educators, and healthcare professionals in advocacy efforts can lead to systemic changes that benefit women with ADHD.

Conclusion

This study investigated the impact of the current ADHD diagnostic process on women in Canada, revealing significant challenges and barriers faced by this population. Through detailed narratives, seven master themes emerged: Self-Blame, Systemic Ableism, Misogyny, Hitting a Breaking Point, The Importance of Community Resources, Grief, and Self-Acceptance.

The findings illustrate that women with ADHD often endure prolonged periods of unrecognized struggles and self-blame due to late diagnoses. Systemic ableism, particularly within educational and professional settings, and misogyny further complicate their diagnostic journey. These systemic issues highlight the urgent need for gender-sensitive diagnostic criteria and more empathetic approaches from healthcare providers.

Participants frequently reached a breaking point during their time in college or university, where the demands of higher education intensified their struggles. Community resources,

especially online communities, provided essential validation and support, which were often lacking in traditional medical settings. The profound sense of grief over missed opportunities and unnecessary struggles underscores the importance of timely and accurate diagnoses to prevent negative emotional outcomes. Despite these barriers, receiving a diagnosis led many participants toward a journey of self-acceptance. This process involved developing greater self-compassion and effective coping strategies, which significantly improved their quality of life. The findings suggest that self-acceptance can be facilitated through accurate diagnosis, supportive resources, and personalized coping strategies.

Key takeaways from this study include the necessity for comprehensive reforms in the ADHD diagnostic process. This includes developing more inclusive diagnostic criteria, better education and training for healthcare professionals, and increased awareness of ADHD's gender-specific manifestations. Strengthening community resources and addressing systemic ableism and misogyny are essential steps toward improving the diagnostic experience and outcomes for women with ADHD in Canada.

By addressing these gaps, we can foster a more supportive and inclusive environment for women with ADHD, ensuring they receive the timely and accurate support they need to thrive. Creating such environments has been shown to improve mental health and academic outcomes for neurodiverse individuals by reducing stigma and providing targeted interventions (Quinn & Madhoo, 2014). This study contributes to the ongoing discourse on gender disparities in ADHD diagnosis and provides valuable insights and recommendations for future research, policy, and practice.

Limitations

I used Interpretative Phenomenological Analysis (IPA) in this study with careful consideration in capturing the authentic voices of women impacted by the ADHD diagnostic system in Canada, however there are inherent limitations due to it being a master's thesis (Smith, Flowers, & Larkin, 2009). Time, budget, and accessibility constraints influenced the research design, including the length of the interviews, the number of participants, and the decision to conduct interviews via Zoom.

I conducted the interviews over Zoom, lasting only 60-90 minutes. While this approach made the research accessible and feasible within the project's scope, it limited the depth and richness of the data I could have achieved through longer, more immersive interviews. Being in participants' lived environments would also have provided a deeper understanding of the social, cultural, and contextual factors influencing their experiences with ADHD diagnosis. However, logistical and financial constraints prevented this approach. Despite these limitations, the interview format allowed me to gather meaningful insights into their diagnostic journeys and identify concrete examples of interventions that could help women navigate the current diagnostic system now.

The study's small sample size also reflects these limitations. I included only four participants, which constrained the diversity of experiences and perspectives captured. Although this aligns with the idiographic focus of IPA, a larger sample would have enhanced the variability and robustness of the findings. By relying on retrospective interviews conducted remotely, I may have further constrained the interpretative depth that IPA seeks to achieve, as in-person engagement often offers richer, more nuanced data. Despite these constraints, the data

highlights the nuanced impact of systemic practices on women through detailed, in-depth narratives (Smith et al., 2009).

The average time from diagnosis to the participant's interview was 3.5 years, providing participants with an opportunity to reflect on their diagnostic experiences with some distance while still retaining relatively fresh recollections. This timeframe is also reflective of a broader reality: women with ADHD are frequently diagnosed in adulthood, often after years of navigating symptoms without a formal diagnosis. Despite this interval, the data highlights the nuanced impact of systemic practices on women through detailed, in-depth narratives (Smith et al., 2009). Additionally, I relied on self-reported data, which may introduce recall bias, as participants' recollections of their experiences could be influenced by current perspectives or emotions. This limitation is particularly relevant given that adults with ADHD often struggle with memory recall, a characteristic noted in the DSM-5 (American Psychiatric Association, 2013). While the 3.5-year average period allowed for meaningful reflection, it also underscores the need to consider how retrospective accounts might be shaped by the effect of ADHD on memory recall.

Future Research

Personal narratives remain crucial for understanding the impact of systemic practices, particularly in capturing the nuanced experiences of women with ADHD. The stories collected in this study provide deep insights into how systemic ableism, misogyny, and other barriers affect their lives, offering perspectives that quantitative data alone cannot capture (Goodley, 2014; Mao & Findling, 2014). Qualitative research, therefore, plays a vital role in exploring the complexities of lived experiences. This approach also allowed participants to identify specific, actionable recommendations for interventions, such as providing clearer diagnostic criteria, improving

healthcare provider training, and enhancing community resources to support women through the diagnostic process.

For future research, I recommend incorporating more immersive and longitudinal methods, such as ethnographic approaches or mixed methods, to build on these findings and enhance their transferability. Ethnographic methods could offer a more in-depth look at participants' day-to-day experiences, capturing the ongoing effects of ADHD and the diagnostic process. Mixed methods could combine qualitative insights with quantitative data to provide a broader, more comprehensive understanding of the systemic challenges women face. These approaches would further illuminate the evolving nature of the ADHD diagnostic journey for women and offer additional, evidence-based recommendations for systemic change.

Dissemination

The study is employing Knowledge Mobilization (KMb), a concept defined by Bennet et al. (2007) as the collective effort of researchers to effectively disseminate and engage with their research, creating value and practical applications for stakeholders. This involves not only sharing research findings but also co-constructing knowledge with stakeholders on how the research can be used to best meet the community's needs. Phipps (2011) elaborates on this concept, discussing York University's development of guidelines and suggestions for students and faculty to enhance their use of KMb for research dissemination.

I will implement selected KMb strategies for this study, recognizing resource and time constraints. Initially, I will develop clear and accessible research summaries, ensuring that a diverse audience can understand and engage with the study's findings. These clear language summaries lay the foundation for research translation, facilitating critical engagement by researchers from various disciplines.

The research translation process will prioritize reaching specific groups who can benefit from these findings and act on the recommendations. In addition to submitting the research to multiple conferences and journals to foster multidisciplinary interaction, I plan to tailor dissemination efforts to reach key vested parties such as healthcare providers, educators, and advocacy groups focused on ADHD and neurodiversity. By sharing clear language summaries on various social media platforms, I aim to engage meaningfully with a broad audience, including people with ADHD, their families, and online communities actively discussing ADHD.

To refine and adapt the recommendations for different audiences, I will create targeted resources—such as visual infographics for social media, short videos, and accessible handouts for healthcare and educational settings. This approach not only makes the research findings more accessible but also addresses the unique needs of each group. Engaging directly with these communities will allow me to gather feedback and refine the recommendations to ensure they are practical and actionable in real-world settings, thereby enhancing their impact on policy and practice.

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Appendix A

Consent Form

Date: Monday, March 25, 2023
Project Title: Investigating the Impact of the Current ADHD Diagnostic Process on Women in Canada

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INVITATION
You are invited to participate in a study aimed at delving into the nuanced experiences of women diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) in Canada. This research seeks to uncover the multifaceted journey of women navigating through the complexities of ADHD diagnosis, treatment, and support systems. By participating, you have the opportunity to shed light on the unique challenges, triumphs, and barriers encountered along the way, offering invaluable insights that could shape future diagnostic practices and enhance the quality of care provided to women with ADHD. Your contribution to this study holds the potential to empower not only yourself but also countless other women grappling with similar experiences, fostering a supportive and understanding environment within the healthcare community.

WHAT'S INVOLVED
As a participant, you will be asked to engage in an interview over zoom where you will share your experiences related to ADHD diagnosis and treatment. This interview will involve discussing topics such as your journey to diagnosis, challenges faced, coping strategies employed, and thoughts on the diagnostic process. Participation in the interview will take approximately 60 to 90 minutes of your time. The interview will be reordered on the researcher's computer and a transcript will be created. Both the video and transcript will be double password secured. During the interview, you will have the opportunity to share your story in a supportive and non-judgmental environment. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish. You will have one week from the week the email is sent to confirm the accuracy of the transcript via email. Your

insights will contribute to research aimed at improving ADHD diagnosis in women, potentially benefiting others facing similar challenges.

POTENTIAL BENEFITS AND RISKS

By participating in this study, you have the opportunity to gain a deeper understanding of your experiences with ADHD and contribute to research aimed at improving ADHD diagnosis in women. Your insights and perspectives may help enhance diagnostic processes, benefiting not only yourself but also individuals in similar situations. Additionally, sharing your story can provide a sense of validation and empowerment, knowing that your voice will inform future research and potentially influence healthcare practices. Furthermore, participation may foster a sense of community and solidarity with others facing similar challenges, reducing feelings of isolation often associated with ADHD.

You may experience mild emotional discomfort or distress when discussing personal experiences related to ADHD diagnosis and treatment. To mitigate these risks, I will create a supportive and non-judgmental environment during our interviews, allowing you to freely express your thoughts and feelings. You have the right to withdraw from the study at any time without repercussions. If you feel distressed during the interview, I will encourage you to seek mental health resources and may terminate the interview if necessary. Your well-being and comfort are my top priorities throughout your involvement in the study.

Mental Health Resources
Suicide Hot-Line
Call or text 988
Access immediate support if you are having suicidal thoughts.

911 Emergency Services
If you are in immediate danger or need urgent medial support, call 911.

Canadian Mental Health Association
Website https://cmha.ca/find-help/find-cmha-in-your-area/
Access mental health supports in your community regarding mental health concerns.

CONFIDENTIALITY

Data collected during the study "*Investigating the Impact of the Current ADHD Diagnostic Process on Women in Canada",* including audio recordings of interviews and transcripts, will be stored in an encrypted folder on a firewall protected computer. All data will be deidentified meaning that any identifiers will be removed. The consent from will form will not be attached to the interview once completed to ensure the data is deidentified. This ensures that all data (consent forms, audio recording and transcripts) are kept confidential. Consent forms and participant emails will be deleted after the study is completed. Our interests are in the average response of the entire group of participants however in order to best authentically represent the

participant's voices direct quotes will be used. While quotes from interviews may be used in reports or publications, they will not be attributed to any specific individual, protecting your anonymity. All audio recordings, transcripts and your consent form will be destroyed once the study is completed unless secondary access consent is provided (see below). Audio recordings, transcripts, and consent forms will be permanently deleted from the computer, securely deleted from the computer using data shredding software that overwrites the files multiple times, rendering them irretrievable. Transcripts will be printed for data analysis purposes. The transcripts will be stored in a locked cabinet in a locked room. Once the study is completed all physical copies of the transcript will be shredded and securely destroyed. Access to this data will be restricted to Rachel Henderson and Dr Jan Frijters (unless you consent to secondary access see paragraph below), ensuring that your privacy and confidentiality are protected throughout the study and beyond.
Please see Zoom's privacy policy regarding the security of the interviewhttps://explore.zoom.us/en/privacy/

Secondary Access

Your participation in our study holds significant potential to shape future research and contribute to scientific knowledge about ADHD in women. Secondary access refers to the ability of other researchers to gain access to your transcripts for purposes of research, data analysis, program development etc. The only data that would be shared would be a transcript of your interview. The transcript will include no personal identifying information. To gain secondary access other researchers will have to contact the primary student investigator (Rachel Henderson) or the supervisor (Dr Jan Frijters) and request access. Access will only be given to researchers who provide detailed information regarding the use of the transcripts. By allowing secondary use of anonymized data, we aim to maximize the impact of our findings. The only data that will be kept is your transcript. Additionally after 10 years all transcripts will be permanently deleted using data shredding software. Through publication of our study findings in academic journals and presentations at conferences, we seek to amplify awareness of the unique experiences and challenges faced by women living with ADHD. Your consent to share anonymized data ensures that your voice continues to resonate in academic and clinical communities, influencing future research directions and advancements in ADHD management. Secondary Access to your transcripts is not a requirement for participation for this study.

VOLUNTARY PARTICIPATION
Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled. To withdraw from the study please email the Rachel Henderson at rh21lk@brocku.ca. All of your data will be deleted and/or shredded if you decide to withdrawal from the study. After the study is completed, you may withdraw your consent for your direct quotes to be used however any general conclusions made from the data will not be able to be removed. In the case that you withdraw your consent after the study has been completed your data will be deleted and/or shredded.

PUBLICATION OF RESULTS
Results of this study may be published in professional journals and presented at conferences.

CONTACT INFORMATION AND ETHICS CLEARANCE
If you have any questions about this study or require further information, please contact Rachel Henderson or Jan Frijters using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University **[insert file #]**. If you have any comments or concerns about your rights as a research participant, please contact the Office of Research Ethics at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

REQUEST FOR FINAL RESEARCH PAPER

If you would like access to the findings of the paper, please check the box below. An electronic copy of the final research paper will be emailed to you once the study has been completed.
☐

CONSENT FORM
I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____
Date:_____

SECONDARY CONSENT FORM
I agree that the researchers can use my data for secondary uses as described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____
Date:_____

Appendix B

Interview Questions Adapted from Young et al., 2008

Demographics Questions

Current Age:

Age at Diagnosis:

Geographic area at time of Diagnosis:

Pre-diagnosis perception of barriers

- Did you notice any differences in how you learned or experienced life when compared to your peers?

  Prompts: Attention span, sitting still, interrupting, maintaining relationships

- Did you face any barriers or obstacles due to these differences?

  Prompts: Difficulty in school, relationships, friendship, finding people who understood your learning style or communication style, organization

- How did you manage/respond to these differences/barriers prior to your diagnosis?

  Prompts: Did you talk to anyone about it? School interventions? Did you have any skills you practiced?

- Before your diagnosis, did you have any idea of what could be causing you to be "different" from your peers?

  Prompts: Anxiety or experiences, self-blame. Obtain specific examples

- Did anyone around you have any theories about what caused these differences? If so, did they offer any solutions to "help" reduce your challenges?

  Prompts: Family, friends, teachers, colleagues, ex. Anxiety

- Follow Up Question: Do you feel that gender effected the way people viewed your barriers/challenges?

  Prompts: Did you see others with a different gender being treated different than you? Did they have access to different resources?

Self-Perception prior to diagnosis

- How did these differences affect your view of yourself?

  Prompt: As an individual? What they liked/didn't like about themselves, self-esteem, confidence, control, abilities, skills

- How do you think others perceive you prior to your diagnosis?

  Prompt: Thoughts and feelings on personality and character

Attempt at a Diagnosis prior to ADHD diagnosis

- Did you reach out to healthcare professionals or seek any assistance before receiving an ADHD diagnosis related to the barriers you faced?

  Prompt: What specific barriers/difficulties caused you to reach out, and did you receive any support?

Seeking the Diagnosis

- Tell me about your journey to obtaining your ADHD diagnosis.

  Prompts: Did you actively seek it, or did someone suggest it to you in response to the barriers you encountered? Was it in response to social media?

The Diagnosis Process

- What type of healthcare professional started the diagnosis process, and who ultimately provided you with the diagnosis?

Prompt: Family Dr, Psychologist ex.

- Approximately how long did the process take from first consultation to diagnosis?

- Was there any fee to receive the diagnosis, and how did that impact your feelings regarding getting a diagnosis?

  Prompt: Approximately what was the fee? Did the fee delay the diagnosis?

- How did the questions and assessments during the diagnostic process make you feel, and do you feel like they addressed your experiences accurately?

  Prompt: Were the questions relevant to your current experience?

- Was your childhood discussed in your diagnostic process, and how did it make you feel being asked about your childhood experiences?

- In your opinion, what role did your childhood symptoms play in receiving your diagnosis?

- To what degree did you feel like your experiences were heard and/or seen by the medical professional during the diagnostic process?

  Prompt: Did you feel like your experiences were taken seriously by the healthcare professional?

  - Follow Up Question: Do you feel that your gender effected your diagnostic process?

    Prompts: Where the questions relevant to your experiences?

- What (if anything), in your opinion, would have made the diagnosis process easier for you, and do you have any suggestions to improve the current diagnosis process?

    Prompts: Process being shorter, More accessible info about ADHD, More relevant questions

Perception after the Diagnosis

- Have the barriers you face changed as a result of your ADHD changed since your diagnosis?

    Prompts: Are they easier to navigate? Are there new barriers?

- Have your feelings about the barriers you face changed after receiving your diagnosis?

    Prompts: Are you frustrated about the amount of barriers? Do you feel like you can manage them better? Do you look back on your previous barriers?

- After receiving your diagnosis, how do you manage your ADHD, and what type of tools are you using?

    Prompts: Therapy, ADHD groups, medication, exercise

- How did receiving your diagnosis affect your perception of yourself (if at all)?

    Prompt: As an individual? What they liked/didn't like about themselves, self-esteem, confidence, control, abilities, skills

- Do you think others have a different perception of you since the diagnosis?

    Prompt: Thoughts and feelings on personality and character

- If you could go back in time and tell yourself something prior to receiving the diagnosis of ADHD, knowing what you know now, what would it be?

Prompt: It could be about the barriers you faced, the diagnosis experience or self-perception.