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"I Am Not Catastrophically Deficient" and Other Profound Learnings: Commentary on an Exploration of Women's Experiences with an Adult Diagnosis of ADHD

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Abstract

The purpose of this Commentary is to provide context for the study titled, "Rediscovering 'Me': A consensual qualitative analysis of the experiences of Australian women with an adult diagnosis of ADHD"; to present an overview of the findings of that study; to highlight progress in research and clinical contexts; and to make recommendations for research and clinical practice pertaining to women with ADHD. It will be identified that, despite noted improvements in the understanding of the ways in which ADHD presents in girls and women, there remains a consequential data gap with implications for the conceptualization, assessment, diagnosis, and treatment of ADHD in women. Of particular relevance are persistent misconceptions which contribute to missed and late diagnoses of ADHD in women, diagnostic frameworks that insufficiently capture women's experiences with ADHD (including, but not limited to, the impact of hormones on symptom presentation, psychosocial impact, and medication efficacy) and a lack of evidence-based therapeutic support that specifically targets the unique challenges faced by women with ADHD. Whilst progress is underway, historical and ongoing inequities remain barriers to timely diagnosis and effective support for women with ADHD.

Keywords: Attention deficit hyperactivity disorder, ADHD, ADHD in women, Late diagnosed ADHD

The Catalyst

When several of my female clients in their mid-40s reported a recent diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in quick succession, I became curious. These clients shared characteristics of being objectively successful and accomplished career women, who had presented for counselling with indicators of burnout. Obtaining an ADHD diagnosis meant that their physical exhaustion, emotional overwhelm, and general feelings of "not coping" were reconceptualized within a frame of living with undiagnosed ADHD whilst juggling the demands of parenting, partnering, and careers, all exacerbated by perimenopause.

These women had engaged in help-seeking attempts across their lifespan. Often commencing in adolescence, they had sought help and clarification about their self-described "deficiencies" and had been diagnosed with anxiety and/or depression, and sometimes other conditions such as bipolar disorder or borderline personality disorder. They had engaged in therapy and/or medication for these diagnoses and had experienced limited, if any, benefit. Subsequently, they had formed the belief that they were fundamentally broken and just needed to "try harder", "be more organized" and "stop being so sensitive" because the treatments they were given for the diagnoses they had received were ineffective.

For my clients, the diagnosis of ADHD was validating and provided helpful context for decades of wondering, *"Why can't I just…?"* For me, their diagnoses raised bigger questions, particularly for medical and helping professionals from whom assistance is sought by women who reach their version of a "breaking point" and would benefit from the clarification that comes from an ADHD diagnosis. These bigger questions were, *"How did we miss this?"*, closely followed by, *"What does this mean for the women being diagnosed, for those who may benefit from a diagnosis, and for those who are supporting them?"*

The Context

The study reported in "Rediscovering 'Me': A consensual qualitative analysis of the experiences of Australian women with an adult diagnosis of ADHD" [1] was conducted in recognition of the paucity of research that had explicitly investigated the unique experiences of women with an adult diagnosis of ADHD. The data were clear – diagnostic rates have risen rapidly in this group in recent times [2,3], however there was a notable gap in research that explored what this experience meant for the women receiving the diagnosis.

My colleague and I set out to conduct a small qualitative study that would include interviews with women who had received a diagnosis of ADHD in adulthood. Our goals were modest and our aim simple: begin a conversation that was overdue and ask questions about what it was like living with undiagnosed ADHD; what catalyzed their diagnosis; their experience of the process of obtaining a diagnosis of ADHD; the impact of receiving a diagnosis of ADHD; and how they were being supported post-diagnosis. In addition, we wanted to understand the specifics of the Australian context and the ways in which the education, health, and employment sectors influenced the experiences of women with ADHD.

The Clamour

Despite our modest intentions, this study quickly morphed into something much larger than we had anticipated. The University of Queensland's media team advertised the study to local media outlets, and it was swiftly featured in a range of local and national publications, including radio and print media. An overwhelming response to our invitation to submit expressions of interest (EOIs) to participate in the study resulted in 1,100 EOIs within four days, at which point we shut down the EOI process. It was evident we had inadvertently stumbled upon a highly salient topic, and many women wanted their voices heard.

From the initial sample of 1,100 EOIs, 477 women provided quantitative data about their perceptions of the psychosocial impact of ADHD. In addition, participants completed measures of mentalization and self-compassion, and the relationships between these constructs were investigated. Analyses indicated significant relationships between low mentalization (especially self-related mentalization), low self-compassion, and high psychosocial impact of ADHD, with self-compassion fully mediating the effect of low self-related mentalization on psychosocial impact. These findings suggested that therapeutic approaches which emphasize the augmentation of mentalization capacity and self-compassion are worthy of further investigation for women with ADHD [4].

In addition to contributing quantitative data, 262 participants provided qualitative data in the form of a video recorded interview (205 participants) or the submission of written responses to the interview questions (57 participants). Transcripts from a stratified sample of 30 participants, comprised of six participants from five age cohorts, representing the age range of all participants who provided qualitative data, were analyzed using the consensual qualitative analysis approach [5].

The Pervasive Impact of ADHD

The qualitative data indicated significant challenges associated with missed and delayed diagnoses of ADHD in women. ADHD was perceived as highly consequential across all domains of life and throughout the lifespan, and systemic barriers to assessment, diagnosis, and support were noted. Older participants reported feeling particularly disadvantaged by the historical context in which they grew up, given the limited understanding of ADHD in girls and women at the times they were pursuing their education and raising their families. Further, the detrimental impacts of persistent myths and misconceptions about ADHD in general, and ADHD in women in particular, were compellingly conveyed. The themes identified are presented in **Table 1**.

The Paradoxes and Complexities of ADHD

A strong theme of "paradox" arose throughout the interviews. It was clear that living with ADHD, both before and after diagnosis, was inherently complicated. For some, the confusion arising from the constant swirl of mixed messages, both from others and from themselves, constituted micro-traumas we conceptualized as "identity injuries". These identity injuries were the result of the paradox of feeling "too much" and "not enough" – often at the same time. Participants reported knowing they were "smart" but feeling "stupid" and feeling as though they were often in a battle between themselves and their brain, which was likened to a problematic toddler that needed appeasing. Participants also reported deep feelings of shame and self-recrimination when they compared themselves to others, inferring that it was much more difficult to for them to perform "simple" tasks compared to their neurotypical counterparts.

Adding to the complexity of living with undiagnosed ADHD were the difficulties associated with overcoming misconceptions about ADHD in women and needing to advocate for themselves in multiple settings to get their diagnosis. The perception that existing diagnostic frameworks do not include important aspects of ADHD, such as rejection sensitivity and emotion dysregulation, and completely overlook sex-based hormonal differences in presentation (with downstream consequences for treatment effectiveness), were also strongly expressed and framed as further exacerbating the challenges associated with obtaining a timely diagnosis and effective treatment.

Table 1. Domains, themes and sub-themes as derived from consensual qualitative analysis.

1. ADHD impacts relationships with self, others and social structures.	
1.1 Relationship with SELF	• Physical wellbeing • Psychological wellbeing • Identity • Trauma
1.2 Relationships with OTHERS	• Difficulties with interpersonal relationships • Relational benefits of ADHD
1.3 Relationships with SOCIAL STRUCTURES	• Education • Employment
2. ADHD is challenging – before, during, and after obtaining a diagnosis.	
2.1 BEFORE	• Missed diagnoses and misdiagnoses • Skepticism and resistance
2.2 DURING	• Logistical barriers to diagnosis • Procedural barriers to diagnosis
2.3 AFTER	• Ongoing challenges with symptoms and impacts • Lack of post-diagnosis support
3. "Paradox" is a defining feature of ADHD.	
3.1 DIAGNOSIS paradox	• Knowledge of diagnosis is helpful, but not a salve, a cure, or a solution
3.2 CONCEPTUAL paradox	• "Deficit disorder" but includes many positives • "Symptoms" as understood through lived experience vs diagnostic criteria
3.3 PROTECTIVE paradoxes	• Masking • Giftedness • Reminders, routines and rituals
4. Misconceptions and misunderstandings about ADHD are persistent and highly consequential.	
4.1 MISCONCEPTIONS	• Stereotypes • Skepticism about diagnosis • Diminishment of impact • Negative attributions
4.2 CONSEQUENCES	• Perpetuates misunderstanding of how ADHD presents in girls and women. • Increases suffering and downstream impacts.

Note. From "Rediscovering 'Me': A consensual qualitative analysis of the experiences of Australian women with an adult diagnosis of ADHD" by Witteveen and O'Hara (2026), *International Journal for the Advancement of Counselling,* p. 8. Copyright (2025) by the Authors, under exclusive license to Springer Science+Business Media, LLC, part of Springer Nature. Reprinted with permission.

Despite these challenges, participants reported experiencing relief and validation when receiving their diagnosis, with one participant poignantly remarking:

> *I am not catastrophically deficient, given my chaos and impulsivity and airheadedness. There is nothing wrong with me, but I am wired differently to others. It means that I am not just a plethora of failings, there are explainable reasons why I struggle with seemingly 'easy' things...I'm not just lazy.*

However, the theme of paradox held true for post-diagnosis experiences also, with retrospective grief (sadness and regret for the suffering that could have been avoided with an earlier diagnosis) and prospective grief (pre-emptive sadness and exhaustion from the knowledge that their ADHD challenges were not something they would grow out of or "cure" with medication and/or an abundance of planners, alarms and reminders) co-existing with the relief and validation derived from the clarity afforded by the diagnosis.

The Consensus

As with any qualitative study, the stories shared by our participants were rich and diverse narratives comprised of unique characters and experiences. However, there were some clear and unequivocal elements to those stories, which represent key learnings that can guide research and practice.

First, myths and misconceptions that trivialize the experience of living with ADHD, whether through dismissal ("everyone's a bit ADHD"), the diminishment of impact ("it's an excuse for bad behavior"), or the fallacy of choice ("just try a bit harder"), are detrimental to those who have a diagnosis of ADHD and those who may benefit from receiving one. A particularly notable misconception that persists is the idea that being "educated" and "successful" are incompatible with having ADHD, and participants reported that skepticism from health care providers based on that belief served as a barrier to diagnosis.

Second, the impact of living with ADHD is not limited to challenges with attention, hyperactivity or impulsivity. Rather, ADHD influences all domains of life, and two almost ubiquitous experiences reported were: (a) exhaustion, with significant implications for physical and psychological wellbeing; and (b) rejection sensitivity as one of the most difficult aspects of ADHD. As current diagnostic protocols do not include exhaustion or rejection sensitivity, there appears to be a disconnect between how ADHD is assessed and how it is experienced.

Third, whilst progress is being made in increasing understanding and awareness of ADHD in women, post-diagnosis support remains lacking. It is evident that existing therapeutic models have limited effectiveness [6] and, despite clinical guidelines indicating efficacy for cognitive behavioral models [7], an overemphasis on cognitive behavioral models is experienced by women with ADHD as frustrating and ineffectual [1]. There is a clear need for the development or adaptation of therapeutic modalities that more appropriately align with the specific challenges associated with ADHD, particularly for women with an adult diagnosis. The negative impact of living with undiagnosed ADHD on identity and self-esteem suggest therapeutic modalities that support identity consolidation and enhance self-compassion hold promise [4].

The Progress

Research momentum

Since this study was conducted, several promising advances have occurred, including research on sex-based and gender-influenced differences in ADHD. Recent publications have examined the impact of ADHD on women across the lifespan, with a particular emphasis on comorbid conditions [8]; the interactions between ADHD and sex hormones in females [9]; psychostimulant adjustments across the menstrual cycle [10]; sex and gender factors in stimulant treatment [11]; and hormonal impacts on symptom expression and psychosocial impact of ADHD [12]. Although this list is not exhaustive, it is indicative of the burgeoning momentum in the empirical exploration of ADHD in women. Cumulatively, this emerging body of literature emphasizes the appropriateness and importance of tailoring ADHD assessment and treatment protocols for different groups and specifically considering hormonal fluctuations across the menstrual cycle and throughout the lifespan in the development of treatment plans [13].

In addition, multiple projects addressing a broad array of topics that are relevant and timely for enhancing understanding of ADHD in women are currently underway at a number of Australian and international universities. Of particular relevance are studies which are exploring physical comorbidities of ADHD and sex-based differences, which have implications for not only diagnosis and recognition of ADHD-related challenges, but also for the provision of effective treatment and support. The need for better understanding of physical comorbidities [8] and the impact of hormones across the menstrual cycle and throughout the lifespan has been clearly articulated [9] and meaningful progress is underway.

Practice initiatives

In Australia, health regulations differ by state and territory, and there are inconsistencies in the regulations pertaining to ADHD diagnosis and prescribing authorizations. The Royal Australian College of General Practitioners (RACGP) recognizes the challenges associated with these inconsistencies and has advocated for nationally consistent guidelines throughout the country [14]. Within this context, there have been a number of state and territory-based initiatives that extend the capacity of general practitioners to prescribe and/or diagnose ADHD [15].

The most substantial reform thus far was implemented in December 2025, whereby the Queensland government introduced reforms to allow general practitioners to diagnose adults with ADHD, as well as to prescribe and manage the ongoing use of psychostimulant medications for adults with ADHD [16]. These reforms represent a strategy to address extended wait times for psychologists and psychiatrists, who were previously the only practitioners able to conduct ADHD assessments and diagnoses in Queensland. At the time of writing of this Commentary (February, 2026) it is not yet clear how these reforms will impact on diagnostic processes, wait times, and access to treatment and support. However, these reforms represent a meaningful attempt to address noted barriers to access, and there is optimism associated with their implementation.

The Continuation

The social and economic burdens of ADHD are substantial [17] and women with ADHD have an elevated risk of negative psychosocial outcomes [18], making women a vulnerable subgroup within an already disadvantaged population. The downstream impacts of delayed and missed diagnoses of

ADHD in women are highly consequential [19] and the need for sex-based and gender-influenced conceptualization, assessment, diagnosis and treatment of ADHD remains pertinent [9,18], as does the development of customized treatments for women with ADHD that go beyond existing recommendations pertaining to cognitive behavioral approaches [1,6]. It is clear that progress has been made, and there are researchers and clinicians actively pursuing projects and policies aimed at increasing awareness and understanding of sex- and gender-based differences in ADHD, so that barriers to diagnosis and treatment are minimized.

This progress is encouraging and provides some assurance that change is not only possible, but also happening in real time. However, in the midst of this busy and important work, it is essential to remain mindful of the "why" behind all of our pursuits – namely, ensuring that women with ADHD are accurately diagnosed and effectively supported in ways that are compassionate, respectful, and affirming. This study elucidated many important findings, not least of which was the necessity of asking questions of those who are best placed to answer them – the individuals with lived experience whose lives we are seeking to improve. It is through listening to their stories that we can make the biggest impact. Now that we have begun asking the questions, it is imperative that we listen to, and act upon, the answers. With that in mind, here is a powerful reminder from one of our participants that, although progress has been made, the work is not yet done.

> *I think the biggest thing is that we're at a bit of a cultural and social and scientific reckoning around the way that ADHD, and neurodiversity more broadly, present in non-male subjects. I would just really like us to have more of a reckoning around the way that we diagnose this. The diagnostic criteria do not work and fundamentally they are not an experience of validation or support. They are an experience that forces us to focus on the negatives. And that is really detrimental when you're dealing with people who are probably being diagnosed because they're already not in a great space. And it still feels to me like there isn't enough education or belief that this is valid and this is real. I know three women who were diagnosed with borderline personality disorder, only to have that reframed into ADHD and autism, because they had the rejection sensitivity dysphoria. I feel like we have made so much progress in so many ways, but we are still telling women that they have hysteria, and that their experience isn't valid, and that it's just about how it impacts the people around them. They can't keep track of the kids' social lives, and they're a bad mother because they can't make sure their house is clean. And we never put that expectation on men. The reason that ADHD impacts women, the reason that we get diagnosed later, is because we get to a point where we can't cope. And that is deeply unfair. And there needs to be accountability.*

Conclusion

This study illuminated historical and ongoing inequities that are artefacts of the substantial data gap pertaining to women with ADHD. Factors contributing to the perpetuation of the problems of missed and late diagnoses of ADHD in women include persistent misconceptions about sex-based and gender-influenced presentations of ADHD, the use of diagnostic frameworks that fail to capture crucial elements of women's ADHD experiences, and a lack of evidence-based therapeutic models that address the unique psychosocial and identity challenges reported by women with late diagnosed ADHD. Research and practice initiatives are gaining momentum, and it is anticipated that this area will continue to attract attention from researchers, clinicians and policymakers. As we strive towards the development of an accurate, comprehensive, compassionate, and effective model of conceptualizing, assessing, diagnosing, and treating ADHD in women, it is essential that the voices of those with lived experience are closely attended to. Achievement of such a model would signify the reckoning described by our participant has, in fact, been realized. This study suggests we are on the path, but there is a long way to go.

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