ATTENTION-DEFICIT/HYPERACTIVITY DISORDER: WOMEN'S ACCOUNTS OF PERSONAL IDENTITY AND SOCIAL SUPPORT

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ABSTRACT

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This qualitative study examines the lived experience of adult women diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) with a specific focus on gender roles and social support. Previous research has identified a potential conflict between symptoms of ADHD and societal expectations of women, in addition to a negative correlation between levels of social support and ADHD symptoms. In the present study, in-depth semi-structured interviews that focused on societal expectations of women and social support were conducted with nine women from ages 25 to 45 diagnosed with ADD or ADHD. Results of content analysis of interview transcripts indicate that most participants perceived themselves as possessing different personal qualities than those societally expected of women. Participants described reacting to these perceived differences by attempting to modify themselves to meet societal expectations, pretending to meet expectations, or intentionally flouting societal expectations. Most participants reported that increased ADHD symptoms led to a decrease in social connectedness, whereas nearly one half of participants reported that increased social connectedness led to a decrease in ADHD symptoms. All participants reported that increased ADHD symptoms led to an increase in comorbid symptomatology. Some participants identified an optimal level of social connectedness and described an increase in ADHD and comorbid symptoms when deviating either above or below the optimal level. Future research should examine adaptive responding to conflicts between socially dictated gender norms and qualities of women with ADHD and examine the concept of an optimal middle level of social connection.

To my family and friends, with love and gratitude.

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INTRODUCTION

Attention Deficit/Hyperactivity Disorder (ADHD) has traditionally been considered a childhood disorder (Canela et al., 2017). However, recent research has revealed that the disorder impacts a significant proportion of individuals throughout the adult life course (Rucklidge, 2010). ADHD is estimated to affect approximately 5% of children in most cultures (American Psychiatric Association, 2013) and between 2.5% and 4.4% of US adults (American Psychiatric Association, 2013; Kessler et al., 2006). Individuals with ADHD are diagnosed with either inattentive or hyperactive subtypes of ADHD, or with combined type, which describes individuals who experience both inattentive and hyperactive/impulsive symptoms (American Psychological Association, 2013). Symptoms of ADHD for those individuals with the inattentive subtype include difficulties with attention to detail, following through on instructions, motivation, and organization. Individuals with the hyperactive/impulsive subtype of ADHD have difficulties sitting still and tend to move and talk excessively, interrupt, and speak quickly (American Psychological Association, 2013). Individuals may be diagnosed with ADHD as either children or adults; to qualify for the diagnosis in adulthood, an individual must be found to have experienced symptoms prior to age 12 (American Psychological Association, 2013). Extant studies do not provide information on the percentage of individuals first diagnosed with ADHD as adults. However, a 15-year longitudinal study of 63 children diagnosed with ADHD hyperactive type suggests that approximately 70% of children with ADHD go on to experience the disorder as adults (Weiss et al., 1985).

Differences in Men's and Women's Experience of ADHD

Late or Missed Diagnosis for Women

ADHD is diagnosed more frequently for males than for females in childhood, at a ratio of 3:1 in community samples (Gaub & Carlson, 1997; Szatmari et al., 1989). By contrast, women and men are diagnosed in adulthood at a ratio closer to 1:1 (Fedele et al., 2012; Chronis-Tuscano, 2022). This discrepancy may be partially accounted for by the fact that boys display higher rates of hyperactivity than girls do, making their condition more noticeable and their diagnosis more likely as a function of their gender (Rucklidge, 2010). For example, Bruchmüller and colleagues (2012) presented 1,000 mental health professionals with fictional profiles of prototypical children meeting either some or all of the ADHD diagnostic criteria. Researchers found that these mental health professionals were significantly more likely to diagnose boys than girls with ADHD given profiles of boys and girls showing identical symptoms. These findings suggest that the mental health professionals surveyed may have relied upon stereotypical views of the presentation of a child with ADHD to diagnose boys who seemed to fit that stereotype rather than adhering strictly to the Diagnostic and Statistical Manual (Bruchmüller et al., 2012). It is worth noting that this study focused on children who were brought to mental health professionals for a possible diagnosis. In reality, girls commonly experience the inattentive subtype of ADHD and may not be brought to the attention of mental health professionals for diagnosis, leading to a late or missed diagnosis (Quinn, 2008; Rucklidge, 2010). In their 2006 review of the epidemiology and management of ADHD in girls, Staller and Faraone conclude based on ADHD prevalence and sex ratios, that at least one million women and girls in the United States and 32 million women and girls worldwide suffer from ADHD, making the understanding of ADHD in girls and women a major public health concern.

ADHD Subtypes in Women Versus Men

In childhood, girls who qualify for a diagnosis of ADHD are diagnosed more frequently with the inattentive subtype than are boys (Weiss et al., 2003; Robison et al., 2008; Rucklidge, 2010). However, studies indicate no such consistent pattern for adults with ADHD. In a study of 219 adults with ADHD referred to an outpatient psychiatric clinic, Biederman and colleagues (2004) found a significantly higher proportion of female than male subjects were classified as qualifying for the inattentive subtype of ADHD according to DSM-IV criteria. By contrast, in their study of 515 adults (335 male, 180 female) who met DSM-IV ADHD diagnostic criteria, Robison and colleagues (2008) found that women were more frequently diagnosed with combined type than were men, while men were more frequently diagnosed with the inattentive subtype than were women. Rasmussen and Levander (2009) found no differences between males and females as regards ADHD subtype classification in a study of 436 men and 164 women referred for diagnostic evaluation for ADHD within the six northern counties of Norway from 1997 to 2004. Similarly, DuPaul and colleagues (2001) found no gender differences in inattentive vs. hyperactive symptoms in their study of 1,209 students with ADHD from three European countries. Data are thus inconsistent and inconclusive regarding differences in ADHD subtype classifications between women and men. In adults with ADHD overall, combined type is the most common ADHD subtype, and hyperactive/impulsive is the least common subtype (Brzezinska et al., 2021).

ADHD Comorbidity in Women Versus Men

Researchers have consistently found that adults with ADHD are more likely than adults without ADHD to experience other comorbid psychiatric conditions (Biederman et al., 2004; Rucklidge & Tannock, 2001; Rucklidge et al., 2016, Hesson & Fowler, 2018). In their study

comparing 158 New Zealand adults with ADHD to 64 adults without ADHD in a control group, Rucklidge and colleagues (2016) found that the lifetime rate of psychiatric disorders was 83% for the ADHD group, as compared with 52% for the control group (Rucklidge et al., 2016). A similar study of 70 German adults with ADHD and 70 age and gender-matched control group participants found that the prevalence of lifetime diagnosis of other psychiatric disorders was 77.1% in adults with ADHD and 45.7% in adults without ADHD (Sobanski et al., 2007).

Although both male and female adults with ADHD cope with frequent diagnoses of comorbid psychiatric disorders, most research indicates that comorbid disorders affect women and men with ADHD differently. Women with ADHD are more likely than men with ADHD to display internalizing conditions such as depression and anxiety (Robison et al., 2008; Rucklidge & Tannock, 2001; Hesson & Fowler, 2018), and more eating disorders (Rasmussen & Levander, 2009; Sobanski et al., 2007), whereas men with ADHD are more likely than women with ADHD to cope with externalizing conditions such as substance use disorders (Biederman et al., 2004; Hesson & Fowler, 2018; Sobanski et al., 2007). It should be noted that a study of 180 US adults (52 females with ADHD and 37 males with ADHD, 51 female and 40 male control group participants) found no differences in levels of self-reported depression and anxiety between females and males with ADHD (Rucklidge et al., 2007). Similarly, in a study of 222 New Zealand adults (158 adults with ADHD, 64 controls), Rucklidge and colleagues (2016) found no gender differences in comorbid conditions among adults with ADHD other than significantly higher rates of past diagnosis of a specific phobia for women with ADHD than for men with ADHD. However, studies of comorbidity have generally found women with ADHD to be more frequently diagnosed with depression and anxiety (Robison et al., 2008; Rucklidge & Tannock, 2001; Hesson & Fowler, 2018) and males with ADHD more frequently diagnosed with substance

use disorders (Biederman et al., 2004; Hesson & Fowler, 2018; Sobanski et al., 2007). It should be noted that similar gender differences also apply to females vs. males without ADHD (Robison et al., 2008; Biederman et al., 2004).

ADHD Severity for Women Versus Men

Research has been mixed regarding whether women suffer greater severity of ADHD symptoms based on studies specifically assessing the severity of ADHD symptoms and level of impairment. Rasmussen and Levander's (2009) study of men and women with ADHD in Norway found that ADHD symptom intensity did not differ between men and women. Biederman and colleagues' (2004) study of 219 adults referred to a large urban hospital in Massachusetts for diagnosis and treatment found that men and women with ADHD did not differ in current total symptom scores, but women reported slightly higher levels of current inattentive symptoms. However, in Robison and colleagues' (2008) study of 515 US adults with ADHD in two large placebo-controlled trials of an ADHD treatment, women were rated as having more severe symptoms on every measure of ADHD symptomatology, as well as more difficulties with in emotion regulation.

Although the data are mixed regarding whether women suffer from greater ADHD symptomatology than men, three studies have shown that women with ADHD suffer greater ADHD-related functional impairment than do men with ADHD. The separate concepts of symptom severity and functional impairment in ADHD come from a 2008 study by Gathje and colleagues, in which they explored the relationship between reported ADHD symptoms and impairment using archival data from 250 male and 64 female children referred to an ADHD diagnostic clinic in central New York. The authors concluded that symptomatology and impairment were related but distinct constructs and should be measured independently.

Three subsequent studies by O'Callaghan and Sharma (2012), Fedele and colleagues (2012), and Fredriksen and colleagues (2014) examined ADHD symptoms and impairment separately, and in all three women with ADHD were found to be more impaired than men with ADHD. O'Callaghan and Sharma surveyed 33 US first or second year medical students (21 male and 12 female) students previously diagnosed with ADHD and found that females had slightly (non-significantly) more severe ADHD symptoms but had significantly greater functional impairment than men as measured by quality-of-life score and psychological health scores. Fedele and colleagues studied gender differences in symptomatology and functional impairment in 164 (72 men and 92 women) college adults with ADHD and found that women with ADHD had higher symptom levels (higher rates of inattention and hyperactivity) than men, as well as higher levels of functional impairment. Furthermore, functional impairment was greater for women even when controlling for their higher levels of ADHD symptomatology. Functional impairment was greater for women specifically in the domains of home life, social life, education, money management, and daily life activities.

Frederiksen and colleagues studied the link between childhood and long-term ADHD symptoms and educational failure and long-term occupational failure in 250 adults with ADHD in Norway, of whom 52% were female and 48% were male. They found that the number of clinician-assessed ADHD symptoms in adulthood as assessed by the structured Diagnostic Interview for ADHD in adults, second edition (DIVA) (Kooij & Franken, 2010) was significantly greater for female participants than for male participants. Additionally, female participants reported significantly more frequent symptoms on the full-scale version and the inattentive subscale of the Adult ADHD Self-Report Scale version 1.1 (ASRS v.1.1) (Kessler et al., 2005). They also found that nearly two times as many women as men reported being long-

term unemployed or out of work in the last year due to disability, and the gender difference remained statistically significant when controlling for age and comorbidity. As the authors point out, this finding could suggest that women are more likely to work in environments less compatible with ADHD, or it could suggest that women are more susceptible than men to disabling consequences of ADHD in an occupational context.

A similar (2019) study of 335 outpatients with ADHD (156 women and 179 men) in Tokyo by Hayashi and colleagues found similarly that women experienced a higher psychiatric comorbidity rate, were less likely to be full-time employees, and were significantly more likely to be divorced than men with ADHD. The authors of this study suggested that women with ADHD experienced these increased difficulties due to "unique Japanese cultural ideals and expectations of women's behavior that are in opposition to ADHD symptoms" (Hayashi et al., 2019, p. 3367). Specifically, the authors describe the Japanese feminine ideal of *Yamatonadeshiko*, in which a woman is expected to be "gentle, modest, reserved, delicate, quiet, attentive, organized, and patient" (Ibid., p. 3368). As will be discussed, women in US society, too, are expected to conform to ideals which may conflict with the natural characteristics of individuals, including women, with ADHD.

Robin & Payson's (2002) study assessed the impact of ADHD in marriage in eighty US couples with one ADHD spouse (44% of couples with the man the ADHD spouse, 56% of couples with woman the ADHD spouse). Husbands without ADHD rated their wives' ADHD to be more significantly negatively impacting their marriage than wives without ADHD rated their husband's ADHD. This finding is consistent with Hayashi & colleagues' (2019) finding that women with ADHD are more likely than men with ADHD to be divorced and suggests that

expectations of women, at least within marriage, may be in conflict with ADHD-related characteristics.

Societal Expectations of Women

Discussing their findings on greater functional impairment in women with ADHD, O'Callaghan and Sharma cite Waite's (2007) article on women and ADHD in considering that ""[t]he gender difference [in functional impairment] may reflect cultural expectations as women's traditional gender role expectations may enhance distress as women struggle with ADHD" (O'Callaghan and Sharma, 2012, p. 656). In other words, women may experience particular distress due to cultural expectations of them (e.g., as naturally organized) that conflict with their own qualities as individuals with ADHD. Indeed, expectations of women as natural organizers of the home goes back thousands of years, at least to ancient Athenian society in which the philosopher Xenophon spoke of women as possessing a "natural gift" given by God for care of the household (Xenophon & Holden, Ch. 7). Women with ADHD today still perceive such societal expectations of gender, which complicate their experience as women whose ADHD symptoms may conflict with stereotypical gender norms. For example, in Holthe and Langvik's (2017) qualitative study examining the role of stigma and gender-specific issues, women described perceiving a discrepancy between their characteristics as women with ADHD and cultural gender norms and expectations of women. One woman in the study stated that "women almost are expected to have an inborn ability to organize and maintain things in order" (Holthe and Langvik, 2017, p. 7).

Several studies of gender stereotypes in American society provide evidence for a potential conflict between the characteristics of individuals with ADHD and stereotypical traits associated with femininity. Blair and Banaji's (1996) study of automatic and controlled

processes in stereotype priming included four experiments evaluating evidence of stereotype priming under various conditions (stereotype-consistent or counter-stereotype intentions and high and low cognitive constraints). In their initial experiment, 73 undergraduates at Yale University (27 men and 46 women) completed multiple trials of timed responding in which they responded to a series of male and female target names preceded by stereotypic, counter-stereotypic, and gender-neutral attributes. As expected, participants responded significantly faster to stereotypic trials in which a masculine name was matched with a stereotypically masculine trait or a feminine name was matched with a stereotypically feminine trait than they did to counter-stereotypic trials in which a feminine name was matched with a stereotypically masculine trait or vice versa. The findings of this experiment indicated that "messy," "loud," "reckless," and "vulgar," all traits likely to be consistent with ADHD, were all considered stereotypically male traits.

Seem and Clark's (2006) study of gender role stereotypes among 121 students enrolled in two masters' level counseling programs in the northeastern US revealed that women are indeed expected to be "very neat in habits" and "very home-oriented," as well as "very passive," "not at all rough," and "not adventurous" relative to men, all stereotypes likely to conflict with the characteristics of women with ADHD. Finally, in their (2015) chapter regarding sex, gender, and work segregation in the cultural industries, Hesmondhalgh and Baker qualitatively analyzed interviews and participant observation research drawn from the industries of music, magazine publishing, and television, concluding that women in these industries are expected to be better organized than men, who are in turn considered more creative due to being less bound by rules. In all of these studies, the traits stereotypically associated with men are more consistent with ADHD-related characteristics than those associated with women, which frequently clash with

ADHD-related characteristics. Additional characteristics associated with women in the preceding studies which would not necessarily be expected to conflict with the characteristics of ADHD include being caring, gentle, and sentimental, as well as irrational, passive and weak (Blair & Banaji, 1996); sensitive, gentle, and compassionate, and creative (Seem & Clark, 2006); and caring, supportive, and nurturing (Hesmondhalgh & Baker, 2015), among other characteristics.

Social Support and ADHD

Despite research findings suggesting that social support both contributes independently to psychological well-being and acts as a buffer in the face of stress (Cohen & Wills, 1985), few studies have considered social support as a potential causal or buffering factor in the level of functional impairment associated with adult ADHD. However, correlational studies have found a negative correlation between ADHD diagnosis and social support (Kok et al., 2016; Bernardi et al., 2012). Although neither of these studies focused specifically on women, Kok and colleagues (2016) reviewed 13 studies of girls with ADHD and concluded that girls with ADHD generally had fewer friends, lower peer status (meaning that they were less liked or more disliked by peers), and lower social skills, and were more likely to experience victimization than girls without ADHD. A similar negative relationship between diagnosis of ADHD and social support appears to exist among adults. In their study of a large national sample of the US adult population of more than 34,000 adults, Bernardi and colleagues (2012) found that ADHD in the US adult population is generally associated with lower perceived social support, lower perceived health and higher perceived stress and higher rates of several comorbid conditions.

Additional correlational studies have focused specifically on the relationship between social support and ADHD symptoms (as opposed to just the ADHD diagnosis), concluding that adults suffering from more severe ADHD symptoms generally experience lower social support

and higher levels of loneliness (Cheng et al., 2014; Stickley et al., 2017). Cheng and colleagues (2014) assessed factors related to self-reported ADHD symptoms among 5,240 incoming university students in Taiwan, and found that those students with higher levels of ADHD symptoms generally reported lower levels of social support, greater emotional disturbance and suicidal ideation, higher tendency toward internet addiction and greater levels of exercise. Stickley and colleagues (2017) used data from the 2007 Adult Psychiatric Morbidity Survey of 7403 British individuals over 16 years old to examine the correlation between ADHD symptoms and loneliness and found that both the presence of ADHD symptoms and symptom severity were positively correlated with level of loneliness.

Although the majority of studies of ADHD and social support are correlational, many have implicitly assumed a deficit model in which ADHD symptoms are presumed to lead to lower social support (Bernardi et al., 2012; Cheng et al., 2014; Stickley et al.. 2017). However, one could equally plausibly interpret the negative relationship between ADHD symptoms and social support in the other direction and conclude that greater social support leads individuals with ADHD to experience less severe ADHD symptoms. Tseng and colleagues (2014) pointed out that previous research on social support and ADHD has been grounded in a symptom-driven perspective and proposed a bidirectional influence of ADHD symptoms on social support or lack thereof and vice versa. They conducted a short-term longitudinal study of 739 Taiwanese 4th and 5th graders using cross-lagged models. The researchers found that children with more symptoms of inattention were more likely to experience subsequent deficits in peer functioning in the form of lower peer acceptance and fewer friendships. In turn, children who experienced deficits in peer functioning were more likely to experience subsequent increases in inattentive and hyperactive symptoms. In discussing these findings, the researchers suggested that negative peer

reactions may lead children to view themselves in a more negative fashion, which in turn leads them to behave more maladaptively. They also point out that their results suggest that peer support may be potentially useful in improving ADHD symptoms.

Social support could be a relevant treatment not only for mitigating symptoms of ADHD itself but for preventing the subsequent development of comorbid conditions such as depression. Both children (Humphreys et al., 2013) and adults experiencing symptoms of ADHD, even if undiagnosed (Able et al., 2007) are more likely than those without ADHD to experience internalizing disorders such as depression. Furthermore, women with ADHD are particularly likely to experience depression (Robison et al., 2008; Rucklidge & Tannock, 2001; Hesson & Fowler, 2018; Brzezinska et al., 2021; Engel-Yeger, 2022). In their study using claims data to examine the prevalence of depression, suicidal ideation, and suicide attempts for 162,263 young women with ADHD and 225,705 young men with ADHD and the same number of control subjects without ADHD for each gender, Babinski and colleagues found that suicidal ideation and depression were more common among women with ADHD than in all other groups (Babinski et al., 2021).

It makes logical sense that depression might follow the years of demoralizing feedback likely to result from ADHD symptoms' effect on school and other realms of endeavor (Chronis-Tuscano, 2022). Indeed, research suggests that initial ADHD symptoms precede the development of depressive symptoms rather than the other way around (American Psychiatric Association, 2000). In their cross-national study of 11,422 adults between the ages of 18 and 44 with ADHD in 10 countries in the Middle East, Europe, and the Americas, Fayyad and colleagues (2007) found that participants recalled ADHD symptoms beginning at an earlier age than all reported comorbid conditions with the exception of specific phobia. Similarly, in their (2015) longitudinal

study of 728 adolescents (54% girls) in the Netherlands, Roy and colleagues found that presence of ADHD symptoms increased risk for future depression.

Three recent studies have investigated the roles of social relationships as mediators of the link between ADHD and depressive symptoms in children and young adults. In two cross-sectional studies of a sample of 230 five- to ten-year-old children and a longitudinal sample of 472 youth followed prospectively from birth to age 20, Humphreys and colleagues (2013) found that peer and especially parent relationship difficulties mediated the relationship between ADHD symptoms and depressive symptoms in US children, whereas academic problems did not play a mediating role. Similarly, Roy and colleagues (2015) found that peer dislike and victimization partially mediated the relationship between ADHD and depressive symptoms in girls but not in boys. Meinzer and colleagues' (2015) cross-sectional study of the covariation between symptoms of ADHD and depressive symptoms in 350 students at a university in Florida found that symptoms of ADHD appear to affect the development of depressive symptoms both directly and indirectly through maternal and paternal support, with higher levels of maternal and paternal support buffering the relationship between symptoms of ADHD and depressive symptoms.

Existing research suggests that lower levels of social support may lead both children and adults with ADHD to experience to more severe symptomatology and depressive symptoms. On the other hand, higher levels of social support are related to lower levels of symptoms of ADHD and appear to buffer the relationship between symptoms of ADHD and depressive symptoms. Social support may therefore be a promising intervention particularly for women, who experience more severe functional impairment due to ADHD symptoms and are more likely to suffer from comorbid depression than men, perhaps due to the perceived conflict between societal expectations of women and the lived experience of being a woman with ADHD.

Present Study

ADHD in women has historically been under-studied (Hinshaw et al., 2021). Evidence suggests that women may struggle disproportionately with impairment due to ADHD, that gender expectations may be a source of tension for these women, and that social support may be an especially promising intervention for women coping ADHD. Yet, little is known about the role of women's perception of gender expectations as they relate to ADHD symptoms and the role of social support in coping with ADHD.

The present study qualitative examines the lived experience of adult women diagnosed with ADHD. Specifically, this study focuses on two primary research questions: (1) How do women with ADHD experience navigating tensions between dominant cultural narratives about women's qualities and their own ADHD symptoms? (2) How do women with ADHD perceive the role of social support in facing daily challenges related to their diagnosis?

METHODS

Overview

A qualitative approach was selected for the present study given a lack of previous empirical research and the complex and multifaceted nature of the phenomenon under study. Qualitative approaches are particularly suited to studies whose goals include understanding the participants' lived experience and helping the participants feel empowered to relate to the research as a way of sharing their insights into their own experience with the broader community (Creswell & Poth, 2018). Unlike quantitative approaches, qualitative approaches encourage the researcher to consciously and intentionally communicate and account for his or her own bias in selecting the topic and means of approach. As a researcher, adopting a qualitative approach allowed me to articulate the manner in which my choice of topic and initial ideas in approaching the study have been shaped by both a review or existing literature and my own personal experience on the topic.

The specific data analysis technique selected for this study was content analysis (Miles et al., 2020), a qualitative methodology in which written or spoken data are systematically classified into themes selected based on similar meaning that represent individuals' experiences of a phenomena (Moretti et al., 2011). Content analysis was selected as opposed to grounded theory methodology, which focuses on generating theories to explain a phenomenon, because content analysis allows the researcher to extract meaning from the data and develop themes representing people's lived experience of the phenomenon (Cho & Lee, 2014).

Participants

The sample for the present study consisted of nine adult women who reported that they had been diagnosed with Attention Deficit/Hyperactivity Disorder (ADHD) or Attention Deficit

Disorder (ADD) at some time in their lives. Women with either an ADHD or an ADD diagnosis were included in the present study since what is currently known as the inattentive subtype of ADHD was classified as ADD prior to the DSM-5 (American Psychiatric Association, 1994). To be eligible to participate in the present research, women had to be at least 21 years of age, diagnosed with ADHD or ADD at some time in their lives, speak English as their first language, and currently reside in the United States. Participants with comorbid psychiatric conditions were eligible to participate in the study but were asked to identify these conditions. A total of 10 interviews were completed for the present study, and one interview was eliminated due to significant deviation from interview topics that made interview data unusable.

Demographic characteristics for this sample can be found in Table 1, and demographics of individual participants can be found in Table 2. Women in this study ranged in age from 25 to 45 years old with a mean age of 31.3 (*SD* = 5.9). Eight participants (88.9%) identified as White and one participant (11.1%) identified as Black. Regarding marital status, two participants (22.2%) reported that they were married, two participants reported that they were single (22.2%), and five participants (55.6%) reported cohabiting with their partners. Four participants (44.4%) reported having children and the average number of children reported by participants who had children was 3.3 (*SD* = 1.7). Regarding current living situation, 77.8% of participants (*n* = 7) reported that they lived with their partner, whereas 22.2% of participants (*n* = 2) lived with their parents. A total of four participants (*n* = 44.4%) reported that they were employed full-time, four participants (*n* = 44.4%) reported that they were unemployed, and one participant (11.1%) reported being employed part-time. One third of participants (*n* = 3) reported that they were currently students. Educationally, one third of participants (*n* = 3) reported that their highest degree completed was a high school diploma. 44.4% (*n* = 4) reported that their highest degree

was a bachelor's degree from a four-year college, whereas 22.2% of participants (*n* = 2) reported that they had completed a graduate or professional degree. The modal household income for participants was between $45,000 and $54,999 per year.

Regarding ADHD diagnosis, 22.2% of participants (*n* = 2) reported that they had received a diagnosis of ADD/ADHD Inattentive Type, 66.7% (*n* = 6) reported a diagnosis of ADHD Combined Type, and 11.1% (*n* = 1) participant did not know her ADHD diagnosis type. Participants in the sample reported that they were an average of 19.2 years old (*SD* = 11.1) at the time of their first diagnosis. A total of 77.8% of participants (*n* = 7) reported taking medication for their ADHD.

In terms of comorbid mental health conditions, 77.8% of participants reported that they were diagnosed with Generalized Anxiety Disorder and 55.4% were diagnosed with Major Depressive Disorder. Seven participants (77.8%) reported multiple comorbid conditions. A total of 77.8% (*n* = 7) of participants reported that they were currently seeing a therapist or counselor and 22.2% of participants (*n* = 2) reported having been hospitalized for mental health conditions once in their lives. One participant reported taking part in one or more online ADHD support groups and no participants reported taking part in ADHD in-person support groups.

Procedure

Participants were recruited from the online discussion forums in six different online communities offering ADHD support: the discussion forums of the organization Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), the discussion forums of the online magazine ADDitude, the website addforums.com, the Women with ADD Facebook group, the ADHD Reddit thread, and the ADHD Women Reddit thread. Women interested in the study were contacted phone to learn more about the research and to discuss study eligibility.

Of the 23 individuals who contacted the researcher, eleven responded to further contact and participated in the phone screening for eligibility, and all eleven met criteria for the present study. Of the eligible participants, ten agreed to participate in the study. However, one participant's responses deviated significantly from the content of the questions to the extent that the interview data was not usable. Of the nine participants included in the final sample, four learned of the study from the ADDitude discussion forum, one learned of it from the CHADD discussion forum, one learned of it from Reddit but did not remember which thread, one learned of it from the website TheMighty.com, an online community for people facing various types of health challenges, and one learned of the study second-hand from her mother but did not know where he mother had found the information. Although I did not post an ad for the study on TheMighty.com, it is likely that someone who saw the ad on another ADHD forum copied it to the ADHD section of that website.

Research interviews were conducted via WebEx, a secure videoconferencing platform and interviews lasted approximately one and a half hours. Interviews were video recorded and saved on the cloud with password protection. Initial transcription of interviews was facilitated by WebEx technology and checked and corrected manually by the researcher. Verbatim transcripts of interviews were used for data analysis.

Measures

The "ADHD, Women's Roles, and Social Support" protocol is a semi-structured interview developed for the present study based on a review of relevant literature (see Appendix A). The interview protocol specifically draws on Fedele and colleagues' (2012) and O'Callaghan & Sharma's (2012) findings regarding symptom severity and functional impairment in women, Holthe and Langvik's (2017) research into societal expectations of women as they relate to

ADHD symptoms, Tseng and colleagues' (2014) findings of bidirectional influence between ADHD symptomatology and peer impairment, and Meinzer and colleagues' (2015) study of parental support as a potential buffer between ADHD and depressive symptoms. The interview protocol is found in Appendix A.

The interview for each participant consisted of 20 primary questions centering around the topics of (1) general background, including demographic information, ADHD diagnosis, symptoms, and challenges, (2) ADHD and identity as a woman, (3) ADHD and other mental health challenges, and (4) ADHD and social support. In the general background section, participants were asked about how they would describe themselves in general, their experience of diagnosis, and challenges with specific ADHD symptoms and areas of life. Consistent with Gaub and Carlson's theoretical distinction between symptom severity and functional impairment, the question of whether functional impairment experienced by the interviewees relates directly to the severity of specific ADHD symptoms was left open-ended. To avoid assuming a deficit-based perspective, the interview also focuses on whether ADHD made the interviewees' lives easier in any regard and open-ended questions about coping strategies regarding ADHD are included in the interview.

Drawing on Holthe and Langvik's (2017) findings regarding women's perception of conflict between ADHD-related qualities and societal expectations of women, the section on ADHD and Identity as a Woman explored whether interviewees believe that their experience of coping with ADHD has been different because they are women, how they perceive societal expectations of women, and whether having ADHD has shaped how they feel about societal expectations of women or of their roles as women. In designing the questions in this section, I was careful to leave open the possibility that ADHD qualities are compatible with societal

expectations of women so as not to lead the interviewees to answer the questions in a way that conforms to previous research findings.

In the section on ADHD and other mental health challenges, interviewee experiences of other mental health challenges were normalized by sharing research findings that many individuals with ADHD also struggle with other mental health challenges. Participants who did identify other mental health challenges were asked if they perceived a relationship between those mental health challenges and ADHD and, if so, how the two were related. I also investigated coping strategies relevant to their other mental health challenges.

In the section on ADHD and social support, participants were asked how socially well-connected they perceived themselves to be and whether they perceived any relationship between their level of social connectedness and ADHD symptoms and challenges. Participants were asked whether they thought their ADHD symptoms influenced the amount that they were connected socially, or whether the amount that they were connected socially influenced their ADHD symptoms. Participants were then asked the same question with regard to the relationship between social support and any comorbid conditions they had identified. I also asked participants about their sources of connection and support, whether they were connected with other women with ADHD, and whether they received social support through the mental health system. If they answered yes to the last question, participants were asked about helpfulness of this source of support relative to other sources of social support in their lives.

At the end of the interview, participants were given the opportunity to share any message or advice that they might like to convey to other women coping with ADHD as well as the general public regarding their experience and to bring up any topic not previously discussed that they thought was important, and to ask questions that they might have.

Researcher Positionality

In keeping with the values and practices of qualitative research, it is important for me to situate myself within the context of the present research. My own experience of being a woman diagnosed with ADHD has shaped both my initial interest in this topic and the ideas that I brought to the research itself. The practice of reflexivity involves being explicit about one's epistemological assumptions and aspects of one's subjective experience that influence various aspects of the research process (Creswell & Poth, 2018). It would be intellectually dishonest of me to pretend that my choice to research the experiences of women diagnosed with ADHD was not shaped by my own experience. The review of relevant existing literature that guided the present research, and the subsequent focus of the present study on specific aspects of these women's lived experience (e.g., societal expectations about being a woman with ADHD, role of perceived social support) have been shaped by my own personal experiences.

The question of whether to share one's diagnosis with study participants is somewhat different than the question of whether to share the way in which one's research is motivated and informed by one's own experience. Similarly to Mira Holthe (2017), who discussed how her own experiences as a woman with ADHD shaped her research, I decided that sharing my own diagnosis with the women in my study is an ethical and useful choice for several reasons. My decision is consistent with the values of community psychology and works to reduce the distinction between academic as "expert" and participant as "subject." I also believe that my own decision to demonstrate openness and trust regarding my experience of living with the disorder may encourage reciprocal openness and trust on the part of the participants.

Data Analytic Strategy

In the present study, I was guided by a content analysis approach (Miles et al. 2020), which incorporated both inductive, "bottom-up" and deductive, "top-down" processes to identify important themes and overarching categories in participant utterances. I used the qualitative coding software Atlas.ti (Hwang, 2008) to manage and analyze my data. As a first step, I read each interview transcript repeatedly to familiarize myself with each participant's account as a whole. I then identified initial broad codes deductively based on major interview topics and questions. Codes identified at this stage spanned the length of the interview, including topics such as General Background, Female Identity, Comorbid Conditions, ADHD and Social Support, and Message for Others. Due to the abundance of data relative to the scope of a master's thesis, I decided to focus further data analysis on three of these five broad topics, namely Female Identity, ADHD and Social Support, and Message for Others.

Next, I began to identify common themes occurring across participant accounts within each of these selected broad initial codes. I revised my coding framework repeatedly to incorporate emergent categories and combine former categories when relevant. I developed operational definitions for each theme, then combined multiple themes at the same level of abstraction into overarching categories, for which I also created operational definitions. I then selected representative quotations for each theme. At the end of this process, an independent coder reviewed a subset of participant utterances that were categorized into themes and overarching categories, and Cohen's Kappa was calculated to establish reliability in claims making. The overall Cohen's Kappa was .97. The values of Cohen's Kappa for the Female Identity, ADHD and Social Support, and Message for Others sections were .897, 1.0, and 1.0, respectively.

RESULTS

Overview

Results of the present study fall into three major topics: societal stereotypes of women as contrasted with the characteristics of women with ADHD, social support and its relationship to ADHD and comorbid conditions, and messages that the participants in the current study wish to convey to others. Within the topic of societal stereotypes of women as contrasted with the characteristics of women with ADHD, findings discussed include the participants' views of societal expectations of women (Table 3), participants' own qualities (Table 4), and participants' responses to not meeting societal expectations of women (Table 5). Within the topic of social support and ADHD, findings include the sources of social support for participants (Table 6), levels of social connectedness for participants (Table 7), the relationship between social support and ADHD (Table 8), the relationship between ADHD and comorbid conditions (Table 9), and the relationship between social support and comorbid conditions (Table 10). Within the topic of messages for others, findings were divided into messages for other women with ADHD (Table 11) and messages for society as a whole (Table 12).

The Unique Experience of Being a Woman With ADHD

When asked about how their experience of ADHD as women differed from a hypothetical man's experience of ADHD, more than half (n = 5) participants described how ADHD was more often overlooked in women than men or suggested that they would have been diagnosed earlier if they were male. As participant 013 stated, "I think [my ADHD] would have been diagnosed a lot earlier. And I think it would have been something that my parents would have taken seriously the first time they heard it." Participant 011 shared her understanding of the reasons women with ADHD are overlooked: "Being a woman, you get that later in life diagnosis;

nobody thinks that you could possibly have ADHD because you're not bouncing off the walls." Interestingly, these five participants were the youngest women in the present study, despite the fact that the older four participants were generally diagnosed more recently and thus had a greater degree of personal experience with late diagnosis.

Nearly half of the sample (n = 4) discussed their experience of increased emotionalism associated with ADHD, which they felt led them to be viewed as "overly emotional," consistent with stereotypes of women. As participant 010 stated, "If you're a woman and you're emotional, it's one of the worst combinations to be. You are automatically viewed...as lesser than or weak…" Although one participant (Participant 004) did not view men's and women's experience of ADHD as different, roughly half of participants identified the problems of under- or late diagnosis and negative views of women based on societal stereotypes.

Societally Expected Roles and Women's Realities

Expected social roles of women identified by participants included traditional roles such as marriage, motherhood, and being the homemaker, and modern expectations of women having a job or career outside the home. The contrast between socially expected roles described by these women and their current realities is often striking.

When asked about the roles women are expected to play in our society, more than half of the sample felt that women are expected to be mothers (n = 7), and nearly half (n = 4) of participants explicitly listed marriage as socially expected of women. Participant 013 identified societal expectation of "the kids, the husband, the 2.5 with the picket fence" as something she had always wanted for herself despite her feminist upbringing. In the present sample, only two participants were married and only four participants were mothers.

More than half (n = 5) of participants reported that women are expected to be stay at home mothers. Participant 010 described herself as "actually kind of fit[ting] into [society's expectations] now that [she had] been working from home and [got] to stay home with [her] son." In contrast, one third of participants described work as a role expected of women, with Participant 004 encapsulating society's expectations of women with the phrase, "To be married, have kids and a job." In actuality, three of the four participants who had children were stay-at-home moms, whereas more than half of participants (n = 5) were employed outside of the home. All participants who felt that women were expected to work were themselves employed outside of the home, although these same three participants felt that women were expected to have children and did not themselves have children.

One third of the sample (n = 3) felt that women are expected to successfully "juggle" competing social roles and to multi-task effectively. As participant 018 put it, "But I think this whole idea that we should be able to… have a career, have a miraculous home, and … have kids, right? And all this stuff and juggle it all. And also, then, have the dinner ready at 6:00… The expectations are just kind of ridiculous." Participants who described women as navigating multiple competing expectations also felt that these expectations were impossible for women to achieve.

Societally Expected Qualities and Women's Characteristics

Participants' view about the socially expected personal qualities of women were categorized into five themes: Participants expressed that society expects women to be *nurturing, nice, organized, poised, and lesser* than their male counterparts. When asked how their own qualities compared with the qualities societally expected of women, eight out of nine participants described themselves as having qualities that did not meet societal expectations of women in

some regard, but some of these women also said that they had qualities that did match societal expectations. The degree to which participants did or did not match societal expectations varied by the personal quality they discussed.

Two thirds of participants (*n* = 6) mentioned that women were expected to possess qualities that fell into the theme of *nurturing*. In addition to explicit descriptions of women as "nurturing," descriptions that fell into this category included caring for others, taking one for the team, putting others' needs first/stepping up, and being a mothering or motherly figure. Participant 015 stated that women are expected to be "that respectful, motherly figure, you know, taking care of the group and being the person that anyone can talk to." Only one participant (Participant 015) described herself as lacking qualities classified as nurturing, pointing out that "[M]y partner probably takes care of me more than I take care of him" and stating that she was OK with going against societal norms in this regard. By contrast, another participant (Participant 013) explicitly described herself as nurturing, stating, "I want to be a stay-at-home mom one day and be with my kids. So, I would say, definitely the nurturing piece. That's a big thing."

Over half of participants (*n* = 5) described women as expected to have qualities that fit into the theme of being *nice*. This theme included descriptions of women as nice, social, emotional/empathetic, docile, a good listener, and a pleaser. As Participant 010 describes, "We are the emotional ones, we are the social ones, the ones that to build relationships…" Nearly half (*n* = 4, or 44% of participants) stated that they did not fit the theme of being *nice*. For instance, Participant 020 stated, "I'm not a people pleaser. I like to help people, but I'm not a people pleaser, like sometimes society might portray a woman to be." By contrast, two participants described as fitting the qualities within the theme of being nice. Participant 018 described herself as "super empathetic," stating that she has "dealt with almost all of the different emotions that

other people talk to me about." Participants were split regarding their level of identification with the expected qualities of being *nurturing* and *nice*, with some women rejecting these characteristics and others embracing them.

Two thirds of participants (n = 6) described women's expected qualities as falling into the theme of being *organized*, which included not only explicit descriptions of being organized but also the qualities of being neat and tidy, focused, taking care of planning and logistics, and keeping the household running. As Participant 011 described, ""You're going to do the laundry, you're going to have it done every single day perfectly. You're going to fold the laundry on time. You're not going to let it pile up. Dishes - same thing." Two thirds of participants (n = 6) stated that they lacked the expected quality of being *organized* or possessed qualities contrary to this theme." As Participant 001 described, "I [used to spend time with] Pinterest ladies and have super fancy organized birthday parties, you know… And I'd be sitting there and being like, "Y'all want to go to a park? Can we just low-key this?" Participant 018 emphasized the discrepancy between cultural expectations that women be organized and the way women with ADHD actually function: "I think it's really opposite, the things that are expected of women vs. having ADHD. They don't go well together. It has taken a lot of my girlfriend yelling at me to get me to actually pick my clothes up off the floor and put them in the hamper." None of the participants in the current study described themselves as possessing the quality of being organized.

In addition to being organized, two thirds of participants (n = 6) described the societal expectation that women be *poised*, a theme which includes not only the explicit description of being "poised," but also descriptions of being well-put-together, meek/quiet, calm/passive, and not fidgety/not impulsive. As Participant 018 described, "I think there's an expectation on us to

hide our shit…that we will… have our hair be perfect and, that we can just hold everything together." Two thirds of participants (n = 6) stated that they lack the quality of being *poised* or have qualities contradictory to it. Participant 011 described herself as lacking this quality as regards the stereotype that women are quiet and meek, stating, "[S]ociety thinks that women should be quiet. Like, there's meant to be, like, meek little quiet beings that just don't speak up and are not loud. And I am… I do not meet that standard in any shape, way, or form. I'm a very loud person. I am outspoken. I talk loudly." No participants identified themselves as possessing the expected personal quality of being poised.

Two thirds of participants described the societal expectation of women as *lesser* than men. This theme included the societal expectation of women as less respected, less athletic, less strong, or less aggressive, less intelligent, and were paid less. For instance, Participant 010 described women as automatically viewed as "lesser than or weak" if they show emotions in a professional context, while Participant 011 described the expectation that women cannot do jobs requiring aggression or assertiveness stereotypically associated with males: "People don't think that women… [can] do an aggressive job, like being a police officer as efficiently, or being firefighter as efficiently…" Approximately half of participants (n = 4) rejected the notion of being lesser to men in domains including intelligence, pay, physical strength, and athleticism. Participant 011 described herself as gifted in the stereotypically male arena of firefighting, while Participant 010 described feeling societal pressure to pretend to be less intelligent than she really is, stating, "I have to tone down my intelligence a little bit [to meet societal expectations]." Participant 018 described her professional and financial success, stating, "I think – no, I know, most 29-year-old women don't have their own consulting firm." By contrast, Participant 001 identified with the stereotype of women as being paid less, stating, "[I]n all of my jobs, I've

actually gotten paid pretty poorly. But I don't know if that's … as an ADHD woman so much as it is a woman being paid poorly." While no participant in the study identified as being lesser to men in ability, one participant did acknowledge experiencing the practical reality of being paid less as a woman than her male counterparts.

In addition to describing themselves as possessing qualities contrary to those expected of women by society, participants identified as possessing other personal qualities. One third of participants (n = 3) attributed to themselves the quality of being *one of the guys* or a tomboy. Participant 020 explained that she "grew up as a tomboy," whereas Participant 018 recounted:

> I have… built a reputation for myself as somebody who, you know, hangs with the guys is one of the guys, whatever. So then when I act more manly people aren't as shocked by it and people like… it's kind of just a part of my reputation now, and it's cool.

Additionally, two participants described themselves as tending toward anger more than is stereotypical for women. Participant 011 stated, "I just kind of hinted that I was the little girl in anger management… Little girls don't get fist-fights. Right, like, that's not a thing, little girls fighting on the playground with boys and stuff like that." In describing themselves as *one of the guys* and as *angry*, participants continued to contrast their own characteristics with those traditionally expected of women.

Two participants also described themselves as having the personal quality of extremes, like Participant 001 describing herself as "hav[ing] two speeds: 0 and 100." Two participants identified having *high expectations* for themselves, as manifested by wanting to prove themselves or being competitive. Participant 013 stated, "But I also know … with my ADD, I always am wanting to prove myself in that sense, too. I got my master's degree, because I really wanted to prove it to myself that I could do it. And I'm toying with getting my doctorate." While

these qualities do not relate to gender, these participants attributed their tending toward extremes and wanting to prove themselves to their experience of ADHD.

Emotional Reactions to Not Fitting Societal Expectations for Women

Eight participants who described themselves as failing to possess at least some personal quality expected of women were asked about what it was like to not meet traditional societal expectations of women. Participants accounts fell into four thematic categories, namely, *self-acceptance, evolving views, ambivalence,* and *frustration.* Participants who experienced *self-acceptance* described a sense of full acceptance of themselves and sometimes described their preference of non-conformity over what they considered conformity to social expectations of women. Participants with *evolving views* described shifting their views on what qualities were desirable for women to come to a place of greater self-acceptance over time. In contrast to these generally positive responses, participants who experienced *ambivalence* described an experience of conflicting feelings about meeting expectations such as being simultaneously self-accepting and self-critical. Participants who experienced *frustration* expressed frustration with being compelled to conform to societal expectations, or with themselves for being unable to conform to expectations.

One fourth of participants ($n = 2$) described feeling *self-acceptance* in response to not meeting societal expectations of women. Participant 010 described her feelings of self-acceptance by stating, "I, actually prefer to be unconventional. I like to go against the grain. It's…one of my values, I just always prize being different, I think because I was different. I was like, 'I like this…. Weird is good. This is what I am.'" Forced to choose between accepting societal views or accepting herself, Participant 010 made defying expectations an important part of her identity.

Two women in the sample described themselves as having *evolving views* about expectations for women and their own qualities in response to not meeting expectations. Participant 005 described the evolution of her thinking by stating, "I always thought that I should be a certain type of person based on my gender alone. But, realizing that I couldn't be those things, no matter how hard I tried, I realized that sticks every person in the same box, so to speak… but it also made me realize that I like being outside the box." Participants with *evolving views* initially attempted to conform to society's expectations but gained confidence in their own qualities over time and ultimately switched strategies and made the conscious decision to prefer their own characteristics.

Two women expressed ambivalence about the conflict between their own qualities and societal expectations. Participant 011 described feeling both acceptance and dissatisfaction in relation to her ADHD-related qualities, stating,

> I've just kind of come to accept it, but sometimes it's frustrating. One, because, like, I do want a child, but at the same time, I'm like, I can't really always take care of myself… and it's hard to accept that people are insecure that I'm loud. People around me, get insecure that I'm loud… My boyfriend's been embarrassed by me before. It's weird that he's been embarrassed … that's something that's hard to cope with."

The participants who expressed ambivalence demonstrated a wish for self-acceptance but simultaneous difficulty reconciling themselves to their ADHD-related characteristics and their consequences.

One fourth of women in the sample described feelings of frustration with themselves or society as a result of their perceptions of societal expectation of women. Participant 020 experienced frustration with having to conform to society's expectations, while Participant 004

expressed frustrating with herself, stating that "…I'm not living up to the expectation and I should. I'm not good enough because I am not doing that." These two participants continued to see society's expectations and their own natural characteristics as incompatible and were frustrated about being forced to change and about the inability to change, respectively.

Practical Responses to Not Fitting Societal Expectations for Women

This sample of women with ADHD also described different practical responses to their sense that they did not meet societal expectations of women. Three participants described having *modified or attempted to modify themselves* in order to fit society's expectations. Participant 020 described violating her general rule of not wearing make-up due to professional pressure, stating, "I don't wear makeup. The only time I ever really did wear makeup was when I had to work in sales and hospitality." An additional three participants described *pretending to meet expectations* by acting differently than they actually were. Participant 018 described playing the part of a polite and poised woman in company meetings: "I think I am very good at pre[tending]. If I have to fit into [societal expectations], I'm really good at it… So, like, go into a meeting, ask somebody for a shit ton of money, usually a man, be very, like… sit there, smile, follow the things." Participants who described *modifying or attempting to modify themselves* or *pretending* were aware of the discrepancy between their own qualities and those expected by society and attempted to minimize the actual or apparent discrepancy.

By contrast, three participants described themselves as intentionally flouting their perceived non-conformity. Participant 004 described choosing not to date, despite the importance of marriage in her culture: "Say with, let's say dating. If I don't feel good about myself, I am not inclined to date, because I feel guilty… Therefore, I'm not likely to start making a connection." In the context of her account, Participant 004 described flouting expectations due to feelings of

unworthiness. Participant 015 described herself as intentionally refraining from cooking so as to not to meet societal expectations, and Participant 018 stated, "I'll be…overly boisterous and talkative at something that maybe usually it would be expected for me to be quiet." Two of these three women described intentionally flouting expectations out of a preference for their own qualities rather than living according to the dictates of society, and one woman attributed her non-conformity to her own feelings of despair and unworthiness.

Sources of Social Support

When asked about the sources of social support in their lives, participants described individuals who were family, friends, mental health or medical professionals, and others. In terms of family members, nearly 80% of participants (n = 7) listed their partners as a source of support. More than half of participants (n = 5) included their pets as a sources of support, and four participants described having supportive children. Participant 010 discussed these three sources together as her family unit, stating, "My closest is definitely my partner [Participant 010 partner] and we have three dogs and a little boy. So that's, like, that's our bubble. The two I'm always with, and that's what I consider my family." Participants' accounts (n = 4) also frequently included parents as a source of social support. Two participants listed one or more siblings as a source of support. Participant 015 described her sister as one of "the next three closest people to me" in addition to her dog. Finally, two participants listed other relatives, including their in-laws and nephew respectively. Participant 001 described the support she receives from her mother-in-law, stating,

> "My mother-in-law has really come alongside me…in the last six months or so. She has a lot more time, and so she's actually been able to… come over, and she'll do the dishes or the laundry… and I talk to her about… things that are hard, and she listens…"

This type of support is especially meaningful for Participant 001, who expressed a longing for a more communal lifestyle in which friends and family would spend time at one another's homes and do chores together. Most participants felt that at least some members of their families were sources of companionship and encouragement.

Participants described three different types of friendships. Two thirds of participants (n = 6) described local friends, or friends whom the participants know and see in person outside of work, as sources of support. Nearly half (n = 4) participants described support from long-distance friends, or friends who live too far away to see regularly but who connect with participants online or by phone. Finally, two participants described receiving support from work friends, friends with whom participants associated specifically through their jobs. Both participants who listed work friends emphasized that these relationships made a great difference to them. Participant 013, who started a teacher social committee at her job, went so far as to say "I couldn't function if I didn't have work friends."

All nine participants described receiving support from the mental health community in the form of therapy, while more than half of participants (n = 5) described receiving support from psychiatrists or family doctors. In fact, 7 out of 9 participants stated in the demographics survey that they currently take medication, which suggests that two participants do see doctors but did not mention them as a source of support. Participants were unanimously positive about the helpfulness of the support they received from their therapists, to the extent that three women explicitly identified mental health professionals as the most helpful of all their sources of support. Participant 013 described her therapist as follows:

> I love my therapist. It was the best decision I ever made… It's just really helpful for her to be the person that's like, "It's okay that you feel this way." She validates my feelings

> in a way that other people … don't know how to… Even though she may not have [the experience of ADHD], she has other clients who do, or are going through similar things, and so she knows what to say. And that's just… so helpful.

A total of 7 out of 9 participants described receiving support from other women with ADHD, and more than half of participants (n = 5) described participating in some form of online community. The women with ADHD described by participants were socially connected to participants in various ways, ranging from family and friends to religious or online communities. Descriptions of the helpfulness of the connection with other women with ADHD varied according to participant. Participant 004 stated that her online connection with a group of women with ADHD "Probably [did] not" help her in coping with ADHD symptoms and that the group was "really where we commiserate." Participant 015, who identified in the course of the interview that "the closest people in my life are the women I know who have ADHD" stated that these relationships do help her cope with symptoms, primarily by "validating issues that I have." Multiple participants described their connection with other women with ADHD as helping them to feel that they're not alone. Most of the online communities listed by participants (such as the one described above by Participant 004) were focused around ADHD, while the online community described by Participant 001 related to other aspects of her life. Participant 001 described struggling to find community in her church and instead turning online to find "a robust song-writing community" and continued,

> I found I really, really loved them, and they're all over the world… I mean, we'll have Zoom calls to talk about art and talk about music… I just love that online community. I find them very encouraging, very supportive of my creativity and my artistic dreams.

Levels of Social Connectedness

Participants were asked about their level of social connectedness, whether they would like to be more or less socially connected, or if they were currently experiencing the right amount of social connection. The majority of participants (*n* = 7, or 77.8%) expressed that they were less connected than they wanted to be. Participant 020 stated, "I would like to be more connected socially in the sense of in-person interaction," pointing out that such connection had become more different in recent months due to the COVID-19 pandemic. By contrast, one third of participants described feeling more connected than they wanted to be. It should be noted that some participants' responses fell into multiple different categories of connectedness. For instance, Participant 005 described feeling both more and less connected than she wanted to be. In answer to the question of whether she felt more or less connected than she wanted to be, she replied, "Oh, that's a hard one, that's both [too connected and not connected enough]… My anxiety says I don't want to be around people, but in general, I want more [connection], because I feel like I need social interaction." Finally, four participants described feeling the right amount of social connection, not wanting to be either more connected or less connected than they currently were.

When Socially Connected the "Right Amount"

Participants were asked what it felt like when they had the 'right amount' of social connection. If participants felt that they currently did not have the right amount of social connections, they were asked to consider a time when they felt good about their level of social connections or to imagine themselves this way. Participants responded that they felt *happy/mentally healthy*, *comfortable*, and that *needs were met* when they experienced or could experience the right amount of social connection. Two thirds of participants (n = 6) stated that

being connected the right amount made them feel *happy* or *mentally healthy*. Participant 010, who felt currently connected the right amount, explained how her social connections had a global effect on her mental health, stating: "It definitely makes my mental health better. It makes things a more even keel all around… [W]hen I get it at a good balance like this, it really carries out into all other areas." One third of participants described feeling *comfortable,* a theme which included descriptions of being comfortable, safe, and calm, at the right level of social connection. Participant 018 stated, "I think when I have the right amount of nurturing, it makes me feel a lot calmer." One third of participants in the sample described *needs* being *met* at an optimal level of social connection. The theme *needs met* included accounts in which participants experienced themselves feeling taken care of and their own needs being met, and also included accounts about their meeting the needs of other people. Whether participants considered themselves to be experiencing the right amount of social connection in the present or not, these women were aware of the positive effects of social connectedness.

Bidirectional Relationship Between Social Connectedness and ADHD

Participants were asked whether they perceived a relationship in either direction between social connectedness and ADHD symptoms. A total of 77.8% of participants (n = 7) stated that having more or more severe ADHD symptoms leads to a decrease in social connectedness. For example, Participant 004 described losing friends as a child due to her ADHD symptoms, stating,

> If I could think back to elementary school… ADHD symptoms caused social withdrawal on acquaintances' parts, … you know, they'd just avoid me or would, due to something I may have said, they would start acting in a certain way towards me, like negatively, or deciding that they need to poke at me. And me not knowing what the hell is going on and

me feeling like I don't have friends because that's what I'm seeing, like people are not wanting to hang out with me.

By contrast, two women in the sample (33.3%) stated that having more ADHD symptoms leads to an increase in social connectedness. Participant 015 described how her ADHD keeps her curious and interested in connecting with people, while Participant 001 (who also said ADHD leads to a decrease in social connectedness in other contexts) described how her ADHD leads her to overcommit to social activities, stating, "That's a thing with us, we have a tendency to over-commit…to say yes to things, but I don't think about it, because I'm trying to make other people happy." Additionally, one participant (Participant 013) stated that she perceived no relationship between ADHD and social connectedness in either direction.

In addition to the effect of ADHD symptoms on social connectedness, nearly half of participants ($n = 4$) perceived a causal relationship between social connectedness and ADHD symptoms such that increased social connectedness leads to a decrease in ADHD symptoms. Participant 020 described relying on social connections to keep her accountable getting up in the morning, stating, "If we have to do something together the next morning, I'm like, "Please come make sure I'm awake. I have an alarm set, but please come make sure I'm awake." In the other direction, two participants stated that they perceived a causal relationship between social support and ADHD symptoms such that increased social support leads to more ADHD symptoms. Participant 005 explained that "[w]hen I don't socialize much, I can focus on stuff better." Participant 011 stated that social connectedness leads to both an increase and a decrease in ADHD symptoms, depending on whether one is over-connected or under-connected relative to a hypothetical optimal level of connection, stating, "How connected I am socially, affects my ADHD because if I am in that state of over-connection with people socially, then I feel

overwhelmed… Being under- connected definitely affects my ADHD because I don't have the social constructs that I need to really stay on task and really stay motivated." Participants' responses indicate that there is a real effect of social connectedness on ADHD symptoms as well as vice versa and Participant 011's response suggests that the relationship between social support and ADHD is not linear but more resembles a quadratic parabola, with the lowest number of ADHD symptoms occurring at a medium, optimal level of social support.

Bidirectional Relationship Between ADHD and Comorbid Conditions

Approximately 80% of adults with ADHD are also diagnosed with comorbid conditions The high rate of comorbidity between ADHD and psychiatric diagnoses typically found among adults with ADHD (Rucklidge et al., 2016, Sobanski et al., 2007) was reflected in this sample in which all of the participants (n = 9) identified themselves in some way as having comorbid conditions. All participants (n = 9) identified a causal relationship between ADHD and comorbid conditions such that increased ADHD symptoms made at least one of their comorbid conditions worse. For instance, Participant 015 stated, "I would say that my ADD symptoms, if I don't manage them properly, then that's when the anxiety symptoms come out." Although all participants reported that ADHD made one or more comorbid conditions worse, one third of participants (n = 3) also stated that there is no relationship between ADHD and at least one of their comorbid conditions. For instance, Participant 011, who stated that increased ADHD symptomatology caused increased symptomatology in her other comorbid conditions, pointed out that there was no causal relationship between ADHD and PTSD. Two participants (22.2%) stated that they perceived a causal relationship between comorbid conditions and ADHD such that increased comorbid symptomatology led to an increase in ADHD symptomatology. For

instance, Participant 020 stated, “I think [my anxiety and depression and PMDD] exacerbat[e] the zero to a hundred of ADHD. And I think it also can exacerbate the inattentive end as well.”

Bidirectional Relationship Between Social Support and Comorbid Conditions

The high rate of comorbid conditions among the study participants suggests that the relationship between ADHD and social support cannot be fully understood without considering the relationship between social support and comorbid conditions as well. To this end, participants were asked whether they perceived any relationship between their comorbid symptomatology and their level of social connectedness. 77.8% of participants (n = 7) stated that increased comorbid symptomatology led to a decrease in social connectedness. Participant 004 described how her depressed mood leads her to avoid seeking social connection in dating: “Right now it’s probably more my mood that affects [my level of social connection]. Say with… dating. If I don’t feel good about myself, I am not inclined to date because I feel guilty.”

Additionally, 88.9% of participants described increased social connectedness as leading to a decrease in comorbid symptomatology. Participant 001 described how her social connection with her new dog improved her depressive symptoms: “Something we did this year that was really helpful… because my husband and I both struggled with a lot of the same issues, he had actually gotten a dog. She’s over there in the bed, a little Beagle. Pain in the butt… loves to be next to me.” By contrast, 66.7% of participants identified that increased social connectedness actually led to an increase in symptomatology. For instance, Participant 010 stated, “I can get overwhelmed with social connections. So, that can make my depression kind of flare up, and there is also the comparison game, the comparison trap that I can fall into.”

As the above results make clear, a majority of participants reportedly saw social connectedness as leading to a decrease in comorbid symptomatology *and* an increase in

comorbid symptomatology. Logically, this suggests that some participants saw social connectedness as leading to a decrease in comorbid symptomatology in some cases and an increase in others. In fact, three participants described social connectedness as helping or hurting their management of comorbid conditions depending on the level of social connectedness. For instance, Participant 018 described both too little and too much social connection as making her anxious, implying some ideal intermediate level of social connection at which she was least anxious: "I think sometimes if I'm too cut off, it can make me more anxious... but I think also sometimes if I… have too much [social connection], like, if I have too much social interaction going on… it starts making me feel like, 'Oh, my God, it's so much,' like, it starts making me anxious as well." This result mirrors the previous finding regarding the relationship between social support and ADHD and suggests that the relationship between comorbid conditions and social support is also quadratic rather than linear.

Messages or Advice for Other Women with ADHD

Participants were asked to share a message or advice about their experiences for other women with ADHD and a message about ADHD for the general public. Three of the messages to other women with ADHD involved connecting to or relating with others. Participants encouraged other women to *know that [they're] not alone/that [their] experience is valid*, to *seek support from others*, and to *be open about [their] ADHD* with other people. One third of participants (n = 3) encouraged other women to *know that [they]'re not alone/[their] experience is valid*. For instance, Participant 005 stated, "[I want to share] that [other women with ADHD] are not alone, that they're still normal. Maybe a different kind of normal, but normal. [I want] to validate them." One third (n = 3) of participants (n = 2) encouraged other women to actively *seek social support and/or external* structure from others. The support sought from others ranged

from emotional support to help structuring one's time. For instance, Participant 011 encouraged women with ADHD to "[f]ind people who are open to listen to what you have to say and are going to be supportive of you and what you have to say no matter what," whereas Participant 004 framed the need for support in a more structural sense, stating, "You require external structure and support, and that's not a bad thing, if you can afford it." Finally, 22.2% of participants (n = 2) encouraged other women with ADHD to *be open about [their] ADHD*, to make known, talk about, or otherwise share their experience of ADHD with the general public. Participant 001 stated, "I think we need to, to keep talking about it. ... and make it more common knowledge." Although only two or three women mentioned each of these themes, the number of themes involving connection with others suggests that this is a central concern and source of help for participants.

Four additional themes related to making the best of life with ADHD. Participants encouraged other women with ADHD to *do [their] research* on ADHD, to *appreciate the gifts of ADHD* rather than seeing it as a purely negative thing, to *decide [their] own life direction*, and *stay in the present moment* rather than regretting the past. A total of 44.4% of participants (n = 4) encouraged other women with ADHD to *do [their]* research about ADHD, to take it upon themselves to learn about the symptoms of ADHD, ways of coping, and resources available to them. Participant 020 advocated for women doing their own research on ADHD: "I would share the value of education, of learning more about what [ADHD] is … if you don't already. Because in my case, I didn't. Just learning more about what it is to help you understand yourself better. That's what it's really done for me." The encouragement to do one's own research on ADHD was the most common message shared by participants with other women with ADHD.

A total of 22.2% of participants (n = 2) encouraged participants to appreciate the gifts of ADHD. Participant 001 described the advantages that came with ADHD for her, stating,

> There are some great things about [ADHD]… This "ADHD for Smart-ass Women" podcast likes to try to highlight the good things… Sometimes I can super focus and, and get things done, or hyper- focus, I think, is the term, and get things done really, really well… I'm super creative, and I can see connections where people don't see connections. And I apparently am very good in a crisis…

Participant 010 encouraged fellow women with ADHD that they "can do wonderful things" with the power of ADHD "if you know what lights your heart on fire."

Another two participants (22.2%) encouraged women with ADHD to choose their own life direction. Participant 015 stated, "I would say that you can't give up on yourself, and… figure out which direction you want to go with your life." Participant 013 reminded participants to follow the life direction they wanted for themselves and not be derailed by others judgment of them. Finally, Participant 010 encouraged women with ADHD to keep a positive attitude on themselves and their life by staying in the present moment, stating,

> You have to stay in the present moment, because it is really hard to have that feeling of, "I feel like I missed out on a whole life I could have [led], had I had the diagnosis, had I been treating this." It's like, that doesn't matter. It's not bad. [Your life is] not over.

Messages for the General Public

Women's messages to the general public generally made requests of people without ADHD and provided information to the public about women like themselves diagnosed with ADHD. Participant requests to others were categorized into the themes *Don't judge us/Give us grace, Help us, Don't discount us because we don't fit stereotypes, Get better at diagnosing*

ADHD in women, and Know that it's not about you. A total of 44.4% of women (*n* = 4) articulated the wish that others not judge and/or extend grace to them, with Participant 010 stating simply, "I wish people would give us a little bit more grace." One third of participants' accounts were categorized into the theme *Help us*. For instance, Participant 013 advocated for bosses at work actually working with employees to help them stay task rather than simply expecting them to meet strict deadlines without any assistance, stating, "You give me steps, you show me how to do it, and… I can get [the task] done easily." The accounts of two participants (22.2%) were categorized into the theme *Don't discount us because we don't fit stereotypes*. Participant 015 stated, "Don't discount …women with ADD just because we don't necessarily fit the ideal role that we may have been cast for." The accounts of two participants (22.2%) fell into the theme *Get better at diagnosing ADHD in women*. Participant 011 stated, "Do more research [on ADHD in women], like this project that you're doing. Like, actually do true studies on women with ADHD instead of just a boy with ADHD. Rewrite the how the DSM 5 is made; change things to fit women into it too." Finally, one participant utterance (11.1%) fell into the theme, *Know that it's not about you*. Participant 010 articulated the wish that the public would not mistake her struggles with ADHD to be about them, stating, "Stop taking everything so personally. My tardiness is not about you. It's not that I don't like my job, because I love my job. It's not that I, I don't want to be this appointment. It's just that I forgot."

The remaining themes communicated as messages for the general public involved informing the general public about what it is like to be a woman with ADHD. A total of 44.4% of women (*n* = 4) made statements that fell into the theme *Living with ADHD is painful/difficult.* As Participant 004 stated, "[It's] depressing [to be a woman with ADHD], And that's not a very good message to send out, but that's only because I feel depressed." Participant 018 explained

that women with ADHD "always think we are doing something wrong even if we're not." One third of participant utterances (*n* = 3) fell into the theme, *We have strengths*. Participant 001 described how some people are overwhelmed by "people like me, people with this [much] creativity, this [many] crazy and creative ideas," while Participant 013 emphasized the capability of women with ADHD. One third of participant utterances also fell into the theme *Women often hide their struggles with ADHD*. Participant 010 confessed, "I haven't told most of these people that I have ADHD, because I'm too afraid of what they will think." Finally, two participants (22.2% made statements that fit into the theme, *We exist*, which also included informing the public that their experience is real. Participant 005 began her response to the question of what message she would like to share with the general public with the statement, "First of all [I'd like to tell the public] that we exist, you know?"

DISCUSSION

Research suggests that women often struggle disproportionately relative to men with impairment due to ADHD (O'Callaghan & Sharma, 2012; Fedele et al., 2012; Frederiksen et al., 2014; Hayashi et al., 2019), that gender expectations may be a source of tension for these women (Holthe & Langvik, 2017; Blair & Banaji, 1996; Seem & Clark, 2006; Hesmondhalgh & Baker, 2015), and that social support may be an especially promising intervention for women coping ADHD (Tseng et al., 2014; Roy et al., 2015). The present qualitative study examined the lived experience of nine adult women diagnosed with ADHD. This study described how women with ADHD experience navigating tensions between dominant cultural narratives and their own ADHD symptoms and how women with ADHD perceive social support in facing daily challenges related to their diagnosis.

Most participants in the present study described themselves as possessing qualities that did not meet societal expectations of women in some regard. Two thirds of participants described themselves specifically as not organized and not poised, while nearly half of participants described themselves as not "nice" in a traditional feminine sense and felt that they were not lesser than men. Participants described various reactions to not fitting societal expectations that included self-acceptance, evolving their views, and experiencing ambivalence and frustration. These women also described taking actions in an attempt to change themselves to meet societal expectations, pretending that they met societal expectations and/or intentionally flouting what they considered societal expectations for women.

Regarding their accounts of social support, most women in the study felt less connected than they wanted to be, and they identified several emotional benefits of having the right amount of social connection. Most participants stated that more severe ADHD symptoms led to a

decrease in social connectedness and nearly half of participants stated that increased social connectedness led to a decrease in ADHD symptoms. All of the participants in the present study were diagnosed with comorbid conditions, most frequently Generalized Anxiety Disorder and Major Depressive Disorder. All participants identified a causal relationship between ADHD and comorbid conditions, noting that increased ADHD symptoms made at least one of their comorbid conditions worse. Most participants (77.8%%) stated that that increased comorbid symptoms led to a decrease in social connectedness, and eight out of nine participants also described increased social connectedness as leading to a decrease in comorbid symptomatology. Surprisingly, two thirds of participants also identified increased social connectedness as leading to an *increase* in symptomatology in some circumstances. Notably, some participants accounts suggested the relationship between social support and ADHD symptoms and the relationship between social support and comorbid symptomatology was more quadratic rather than linear, with the lowest level of ADHD and comorbid symptoms occurring at an ideal intermediate level of social support.

One third of participants' advice to other women with ADHD involved messages about connecting to or relating with others. Participants encouraged other women to know that they're not alone/that their experience is valid, to seek support from others, and to be open about their ADHD with other people. Participants also emphasized the importance of doing one's own research on ADHD. Messages participants wanted to send to the general public focused on wanting people to learn more about women like themselves who are diagnosed with ADHD. Nearly half of participants articulated the wish that others would not judge them or extend grace to them and shared that living with ADHD is painful and difficult.

Late or Missed Diagnosis, Subtypes, and Comorbidity

The relatively small proportion of present study participants diagnosed with ADHD in childhood is consistent with previous research indicating that ADHD is diagnosed more frequently for males than for females in childhood, at a ratio of 3:1 in community samples (Gaub & Carlson, 1997; Szatmari et al., 1989). Only two participants (22.2%) in the present study were diagnosed with ADHD in childhood, despite the fact that symptoms must have been present before age 12 for one to qualify for an ADHD diagnosis at all (American Psychiatric Association, 2013). Additionally, three out of nine participants were diagnosed only in the past three years. These findings are consistent with previous research that suggests that girls showing symptoms of ADHD are under-diagnosed relative to their male peers (Bruchmüller et al., 2012).

The younger five participants in the study were diagnosed at a younger age, on average, than were the older four participants, suggesting that the discrepancy in childhood diagnosis between boys and girls may be decreasing over time. However, the youngest five participants, ranging in age from 25 to 30, all brought up the point that women are less likely to be diagnosed in childhood than men are. By contrast, none of the oldest four participants, who ranged in age from 33 to 45, raised the concern about late or missed diagnosis. This difference may reflect greater psychological knowledge on the part of younger participants, possibly as a result of greater fluency with online technology.

Six women in the present study were diagnosed with combined type of ADHD which is consistent with research that suggests that combined type is the most common ADHD subtype in adults with ADHD overall, and that hyperactive/impulsive is the least common subtype (Brzezinska et al., 2021). Additionally, only two (22.2%) of the participants in the present study were diagnosed with inattentive subtype. This ratio indicates that 77.9% off current study

participants experience hyperactive as well as inattentive symptoms. This means that that the theory that girls are overlooked relative to boys due to possessing fewer hyperactive symptoms (Quinn, 2008; Rucklidge, 2010) does not explain current study findings. Instead, the late diagnosis in the majority of study participants is consistent with Holthe and Langvik's (2017) contention that women with ADHD put effort into suppressing disruptive and disorganized behavior because they perceive these characteristics to conflict with those expected of women in broader society.

Present study findings that 100% of participants were diagnosed with at least one mental health condition are consistent with previous research indicating that adults with ADHD are more likely than adults without ADHD to experience other comorbid psychiatric conditions (Biederman et al., 2004; Rucklidge & Tannock, 2001; Rucklidge et al., 2016, Hesson & Fowler, 2018). Additionally, the finding that two thirds (n = 6) of the current sample were diagnosed with Generalized Anxiety Disorder and 44.4% (n = 4) were diagnosed with Major Depressive Disorder are reflective of previous research indicating that women with ADHD are more likely than men with ADHD to display internalizing conditions such as depression and anxiety (Robison et al., 2008; Rucklidge & Tannock, 2001; Hesson & Fowler, 2018).

Societal Expectations of Women

Present study findings indicate that participants are acutely aware of traditional United States societal expectations that women be *nurturing*, *organized*, *poised*, *lesser*, and *nice*. Clark's (2006) expected female qualities of being sensitive, gentle, and compassionate all map onto the present study's category of being *nice*, while Hesmondhalgh and Baker's (2015) expected female characteristics of being caring, supportive, and nurturing all map onto the present study's category of being *nurturing*. Blair and Banaji's (1996) findings that being "messy" and "loud"

are considered stereotypically male traits suggest the association of the inverse characteristics of neatness and quietness with femininity. Indeed, these characteristics were mentioned by participants and classified into the socially expected categories of *organized* and *poised*. Similarly, research by Seem & Clark (2006) and Hesmondhalgh & Baker (2015) explicitly found that women are expected to be "very neat in habits" and "organized," respectively, both of which map onto the present study category of being *organized*.

The participants in the present study perceived a conflict between their own ADHD-related characteristics and societal gender norms and expectations of women. This finding is consistent with Holthe and Langvik's (2017) findings and with the speculations of previous researchers attempting to explain their findings that women appear to suffer from greater functional impairment than men (O'Callaghan & Sharma, 2012; Hayashi et al., 2019). Two thirds of women in the sample felt that they did not have personal qualities of being *organized* and *poised*. These accounts of participants' personal qualities are not surprising given that characteristics such as being 'messy' and 'disorganized' and "difficulty organizing tasks and activities," or being 'fidgety' are part of the DSM-5's criteria for a diagnosis of ADHD. However, it is notable that participants identified these qualities of ADHD as conflicting with societal expectations of women. In fact, eight out of nine participants described themselves as possessing qualities that did not meet societal expectations of women. Study participants also noted other personal qualities that they felt defied traditional gender expectations.

In the present study, about half of participants ($n = 4$) said that they experienced *ambivalence* or *frustration* regarding the mismatch between societal expectations and their own ADHD-related qualities. These findings may help account for previous research findings that, while women may or may not experience higher levels of ADHD symptomatology than men

(compare Rasmussen and Levander, 2009 with Robison et al., 2008), women have repeatedly been found to experience greater functional impairment (O'Callaghan & Sharma, 2012; Fedele et al., 2012; Frederiksen et al., 2014). The conflict between gender expectations and ADHD characteristics may be especially relevant in explaining why women with ADHD have higher divorce rates than their male counterparts (Hayashi et al., 2019) and why ADHD seems to affect US marriages more negatively when the woman has ADHD than when the man has ADHD (Robin & Payson, 2002).

ADHD and Social Support

Findings from previous research are inconclusive regarding the question of whether women with ADHD use social support as a coping mechanism. Previous studies indicated that girls with ADHD (Kok et al., 2016) and US adults with ADHD (Bernardi et al., 2012) tend to receive less social support than do their non-ADHD peers. Previous correlational studies have also found an inverse relationship between reports of perceived social support and self-reported ADHD symptoms among incoming university students in Taiwan (Cheng et al., 2014) and British adults (Stickley et al., 2017). These correlational studies cannot speak to the directionality of associations between ADHD symptoms and social support. A goal of the present study was to ask women with ADHD directly about their views of the association between their ADHD symptoms and their overall sense of social support.

Social support has traditionally been defined in terms of structure, or how many different sources of support a person has, or in terms of function, the extent to which social relationships provide particular emotional or tangible resources (Cohen & Wills, 1985). In the present study, social support was conceptualized structurally, with participants being asked to identify different types of people who they viewed as sources of connection and support. Participants were then

asked about the relationship between their level of social connectedness, our operationalization of social support, and their level of ADHD symptoms.

Present study findings appear to indicate that women with ADHD view increased ADHD symptoms as reducing their sense of social support. A total of 77.8% of participants described how they felt that their ADHD symptoms reduced their sense of social support, with some women suggesting that their ADHD symptoms put social distance between themselves and others. Some participants felt that ADHD symptoms affected their ability to listen to others and be interpersonally sensitive to others' needs. These findings are consistent with prior research indicating that more individuals with ADHD tend to be single or divorced than individuals without ADHD (Biederman et al., 2006; Fayyad et al., 2007).

In contrast, present study findings also lend some credence to the theory that increased social support acts to mitigate ADHD symptoms. Nearly half of study participants identify increased social support as leading to a decrease in ADHD symptomatology. Using a sample of 4th and 5th grade children in Taiwan, Tseng and colleagues (2014) found that children's inattention symptoms predicted lower social support, which in turn predicted increased inattentive and hyperactive symptoms. According to Tseng et al., negative social reactions to ADHD symptoms may have led children with ADHD to view themselves more negatively, which then led them to behave less adaptively. Present findings suggest a complex picture of the role of ADHD symptoms and perceived social support in these accounts of women diagnosed with ADHD.

ADHD, Social Support, and Comorbidity

For adults with ADHD in general, and for the women in the present study in particular, an understanding of ADHD and social support is not complete without taking into account

individuals' comorbid mental health conditions. Prior research indicates that approximately 80% of adults with ADHD experience at least one comorbid condition, as compared with about 50% in the population overall (Rucklidge et al., 2016; Sobanski et al., 2007). Similarly, women diagnosed with ADHD as adults have found to have more symptoms of anxiety, depression, and lower self-esteem than women without ADHD (Rucklidge & Kaplan, 1997). The higher rate of comorbid conditions is apparent in the current sample, in which all participants identify with some type of comorbid condition.

Regarding the connection between ADHD and comorbid symptomatology, participants in the present study universally experience their ADHD symptoms as making at least some comorbid symptomatology worse. This finding consistent with research indicating that ADHD precedes nearly all comorbid conditions temporally (Fayyad et al., 2007) and suggests that ADHD may in fact be a cause of other conditions and not just a comorbidity. This fact also highlights the theoretical role of social support as a buffer between ADHD and comorbid conditions that frequently result from it, as suggested by previous research (Humphreys et al., 2013; Roy et al., 2015; Meinzer et al., 2015). The findings of the current study are consistent with the theory of social support as a buffer between ADHD symptoms and comorbid symptomatology. Nearly 90% of participants identified an inverse causal relationship between social support and comorbid symptomatology such that increased social support led to a decrease in comorbid symptomatology. Nearly 80% of participants also identified increased comorbid symptoms as leading to a decrease in social support. Together, these findings are suggestive of a positive feedback loop in which an individual feels depressed (for instance), leading her to withdraw from her sources of social support, which in turn may lead her to feel more depressed.

Present study findings generally point to an inverse relationship between social support and ADHD symptomatology and between social support and comorbid symptomatology. However, a few participants also identified a positive relationship between social support and ADHD symptomatology (n = 2) and between social support and comorbid symptomatology (n = 6). The fact that participants described both an inverse and a positive relationship between social support and symptomatology of these two conditions can be explained by the fact that some participants explicitly identified an ideal, intermediate level of social support at which symptoms are lowest. Present study findings also show that most participants (n = 7) feel they are less connected than they would like to be, but a few (n = 3) participants also feel they are too connected in some respect. In other words, the relationship between social support and both ADHD and comorbid symptoms appears to look less like a line than a parabola, with social support leading to a decrease in symptoms up to an ideal level of social support, after which increased social support actually leads to an increase in symptoms. Although this finding has intuitive appeal, more research is needed to explore the idea that there may be an intermediate or optimal level of social support as viewed by women with ADHD.

Messages for Other Women with ADHD and for the General Public

Participants' messages for other women with ADHD in the present study generally focused on the themes of connecting with others and making the best of life with ADHD. One half of participant response categories involved some form of social connection with others. This finding is consistent with previous literature that suggests the helpfulness of social support in coping with symptoms of ADHD (Tseng et al., 2014) and in buffering against comorbid conditions (Humphreys et al., 2013; Roy et al., 2015; Meinzer et al., 2015). Additionally, the most common single thematic category of advice messages to other women with ADHD was *Do*

your research. This theme is unsurprising given the history of most of the participants, and of many women with ADHD more generally, of being overlooked by the mental health field (Quinn, 2008; Rucklidge, 20100. The emphasis that these women place upon research suggests that they have learned the importance of educating and advocating for themselves in settings that have historically been unresponsive to the concerns of women with ADHD.

Women's advice for the general public fell into two overarching categories, *Requests of the General Public* and *Information for the General Public*. Participant requests of the public included *Don't discount us because we don't fit stereotypes* and *Get better at diagnosing ADHD in women*, whereas information about women with ADHD included the theme *Women often hide their struggles with ADHD.*

Notably, these unprompted messages to other women echo earlier research findings that ADHD characteristics are at odds with social expectations of women (Holthe & Langvik, 2017; O'Callaghan & Sharma, 2012; Hayashi et al., 2019), leading women to hide their struggles ((Holthe & Langvik, 2017), and that the mental health system cannot currently be trusted to diagnose ADHD in women reliably (Quinn, 2008). The two most frequent requests of the general public, *Don't judge us/ Give us grace* and *Help us* highlight the importance with which women with ADHD view their social relationships with others without the disorder, and the degree to which they view social support from others as beneficial to their ability to cope successfully with ADHD.

Study Limitations and Directions for Future Research

Although provocative, the present study has a number of limitations. The present study used a small sample which was diverse with respect to age, duration of diagnosis, and range of comorbid mental health conditions. These study characteristics have implications for the

dependability and transferability of present findings. Additionally, the research relies exclusively on participant self-report and no attempt was made to verify ADHD or comorbid psychiatric diagnoses for participants in the sample. Future research is needed on larger samples using qualitative and quantitative forms of inquiry to replicate and extend present findings.

Findings of the present study suggest that the perceived conflict between qualities societally expected of women and the qualities that women with ADHD feel that they possess may add to their psychological distress associated with ADHD. Present findings are hypothesis-generating, and future quantitative studies with large and diverse samples of women with ADHD could investigate ways that societal expectations of women may contribute to psychological distress for women coping with ADHD. Future research could examine how various types of gender role strain may contribute to ADHD symptoms and comorbid psychological conditions. Additionally, future research about women diagnosed with ADHD could examine factors that may lead some women to accept or embrace behaviors associated with ADHD as part of their self-identity.

Present study findings also highlight the importance of further research that examines the role of social support and symptoms of ADHD. Future longitudinal research with adults with ADHD is needed to examine how perceived social support might serve to increase or decrease women's ADHD symptoms. Future research needs to be sensitive to factors such as participant age, life cycle phase, and features of ADHD and comorbid conditions in helping to unravel the complex interplay between supportive relationships and behaviors associated with ADHD. Both qualitative studies of women's lived experience and large quantitative studies of structural and functional social support would contribute to findings that might have direct treatment and intervention implications for women with ADHD.

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APPENDIX A. ADHD, WOMEN'S ROLES, AND SOCIAL SUPPORT INTERVIEW PROTOCOL

*Note: bullet points are follow-ups to questions. Those in parentheses are asked only if participants need additional prompting. In some cases (indicated in the interview), questions in parentheses are asked only if participants have answered yes to the previous question.

General Background: Diagnosis, Symptoms, and Challenges

Please tell me a little bit about yourself?

Now I would like to ask you about your experience with ADHD. Please tell me about when you were first diagnosed with ADHD?

- (What was your experience of receiving this diagnosis?)

People often experience thoughts, feelings, and behaviors growing up that they later come to recognize as related to ADHD. I am wondering about your experiences growing up. Looking back, what thoughts, feelings, and behaviors did you experience as a child or adolescent?

- (What was that like for you?)

Life as an adult involves unique challenges not faced in childhood and adolescence. How has ADHD has made your life easier or harder?

- What aspects of your life would you say having ADHD has affected the most (e.g., work life, home life, driving, psychological health, relationships, school work, childcare, etc.)
- (Please describe how ADHD has affected these parts of your life?)

What ADHD thoughts, feelings, and behaviors do you find most severe or troublesome on a regular basis?

- How severe do you think these experiences are for you compared to most people with ADHD

Do you have any strategies of methods that you use to cope with your ADHD-related thought, feelings, and behaviors and challenges?

- How effective would you say these strategies have been for you?

ADHD and Identity as a Woman

I would like to shift gears a bit now to focus on your views about how society sees women and what it is like for you to be a woman who has been diagnosed with ADHD.

How has being a woman with ADHD, as opposed to just a person with ADHD, has made your experience of ADHD different, and how?

- (How do you think being a woman with ADHD is different from being a man with ADHD?)

In your opinion, are some of society's assumptions and expectations about women?

- (In other words, what qualities and behaviors do you think society thinks the ideal woman should have?)

- How do you feel you personally compare to society's assumptions and expectations about women?
- How do you feel about that?

Thanks so much. Just as a quick follow-up to that last question, has being diagnosed with ADHD shaped how you feel about societal expectations or about your role as a woman?
- (How?)

ADHD and Comorbid Conditions

I'd now like to shift gears again to the topic of other mental health challenges besides ADHD. It is not uncommon for individuals with ADHD to face other mental health challenges besides ADHD. Can you tell me if that is the case for you?
- (If yes: Thanks so much for sharing that. Can you tell me a little bit more about what that's like for you?)
- (If yes: How do you feel [other mental health challenge] relates to your experience of ADHD symptoms and challenges?
- (Specifically, do you think the level of ADHD symptoms that you experience influences the degree to which you experience symptoms of your other mental health challenges, or that level of symptoms of your other mental health challenges that you experience influences the degree to which you experience symptoms of ADHD?)
- (If yes: What have you tried to cope with [other mental health challenge?)
- (If yes: How has that worked for you?)

ADHD and Social Support

Now I would like to ask you a few questions about your social relationships and how they play a role in your life.

How would you describe your social life/ level of connection with friends, family, romantic partner, pets, etc.?
- How do you feel about the amount of social connection you have in your life?
- (Do you have about the amount of connection that you want? Would you like to be more or less connected socially?)
- When you are connected socially the right amount, how does that affect you?

Do you think your ADHD symptoms influence the amount you are connected socially, or that the amount you are connected socially influences your ADHD symptoms?
- (I guess I am asking two questions. First, do you feel like the amount you are struggling with ADHD symptoms at a given time leads you to be more or less connected socially? And second, do you feel like being connected socially influences how easy or difficult it is to deal with you find your ADHD symptoms?)
- (If yes: Can you explain that a bit more?)
- (If yes: Why do you think that is?)
- (If they have described other mental health challenges) I also have the same question with regard to your other mental health challenges and social support. Do you think that symptoms of your other mental health challenges influence the amount you are connected

socially, or that the amount you are connected socially influences your other mental health symptoms and challenges?

I'd like to learn a bit more about your sources of social connection and support. Specifically, how are your closest sources of social support are connected to you (Are they family? Friends? A relationship partner? Coworkers? A pet? Some other relationship?)?

Are you connected socially with other women who also have ADHD?

- (If yes) How would you say that relationship/those relationships compare with your other social connections?
- (If yes) I'm wondering if and how those relationships help you in coping with ADHD symptoms and challenges?

As a final follow-up on this topic, do you receive any other type of social support that we haven't yet touched on such as attending therapy appointments or other formal types of support from the mental health system.

- (If yes) How would you say these experiences compare to other sources of social support in your life in terms of helpfulness?

Message for Others

As this interview comes to an end,

If you had a message to share with other women with ADHD, what would it be?

If you had a message to share with people in general about the experience of being a woman with ADHD, what would it be?

Questions and Conclusion

We've now reached the end of the interview. Thank you again for participating in the study and talking with me today. I really appreciate it. I think it is so important to understand the experiences of women with ADHD and how we can lead our best lives. At this point, before we wrap up, I would like to invite you to share any thoughts on topics you wish I had asked about or and ask any additional questions you might have for me.

APPENDIX B. DEMOGRAPHIC QUESTIONNAIRE

1. How old are you?

2. How would you describe your gender?

3. What is your race/ethnicity?
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Hispanic or Latino/a/x
   - Native Hawaiian or other Pacific Islander
   - White
   - Other race/ethnicity (please specify):
   - Multiracial (please specify):

4. What is your marital status?
   - Single (never married, not living with romantic partner)
   - Cohabiting (not married, living with romantic partner)
   - Married
   - Separated
   - Divorced
   - Widowed

5. Do you have one or more children?
   - Yes
   - No
   - Other (please explain)

6. If you have children, how many children do you have?

7. What is your current living situation?
   - I live alone
   - I live with roommates
   - I live with my parents
   - I live with my partner/spouse
   - Other (please describe)

8. What is your current employment status?
   - I am currently unemployed
   - I am employed part-time
   - I am employed full-time
   - Other (please describe)

9. Are you currently a student at an institution of higher education?
   - Yes

- No
- If yes, please specify what degree you are pursuing

10. What is your highest educational level completed?
    - High school
    - Community college or trade school
    - Four year college (bachelor's degree)
    - Graduate or professional degree

11. What is your approximate annual income (including you and your spouse if married)?
    - <30,000
    - $30,000-$49,999
    - $50,000-$74,999
    - $75,000-$99,999
    - $100,000-$130,000
    - >$130,000

12. Which of these accurately describes your ADD/ADHD diagnosis?
    - Attention Deficit Disorder (ADD)
    - Attention Deficit/Hyperactivity Disorder (ADHD) inattentive type
    - Attention Deficit/Hyperactivity Disorder (ADHD) hyperactive type
    - Attention Deficit/Hyperactivity Disorder (ADHD) combined type
    - I don't know

13. What year were you diagnosed with ADD/ADHD?

14. Do you take medication to treat your ADD/ADHD?
    - Yes
    - No

15. If you take medication to treat your ADD/ADHD, please list the medication(s) that you take:

16. Have you ever been diagnosed with a psychiatric condition other than ADD/ADHD?

17. If so, please list the psychiatric condition(s) other than ADD/ADHD for which you have been diagnosed.

18. Do you currently see a therapist or counselor for mental health reasons?

19. Have you ever been hospitalized for mental health reasons?
    - If so, how many times have you been hospitalized for mental health reasons in your life?

20. Are you currently in any in-person support groups for ADHD?

21. Please list any online support groups for ADHD that you follow or participate in.

APPENDIX C. TABLES

Table 1. Demographics of Sample (n = 9)

Demographic Variable	Sample (n = 9)
Mean (*SD*) age	31.3 *(5.9)*
Gender	
Female	100%
Race	
White, non-Hispanic	8 (88.9%)
Black	1 (11.1%)
Marital status	
Single	2 (22.2%)
Cohabiting	5 (55.6%)
Married	2 (22.2%)
Divorced or separated	0%
Children	
Yes	4 (44.4%)
No	6 (66.7%)
Mean (*SD*) number of children (among those with children)	3.3 (*1.7*)
Current living situation	
With partner/spouse	7 (77.8%)
With parents	2 (22.2%)
Alone	0 (0%)
With roommates	0 (0%)
Employment status	
Full-time	4 (44.4%)
Unemployed	4 (44.4%)
Part-time	1 (11.1%)
Student status	
Non-student	6 (66.7%)
Student	3 (33.3%)
Degree-pursuing	
None	6 (66.7%)
Masters	1 (11.1%)
Associates	2 (22.2%)
Education	
High school diploma	3 (33.3%)
Community college or trade school	0 (0%)
Bachelor's degree	4 (44.4%)
Graduate or professional degree	2 (22.2%)
Annual income	
<$15,000	1 (11.1%)
$15,000-$24,999	1 (11.1%)
$35,000-$44,999	1 (11.1%)
$45,000-$54,999	4 (44.4%)

$85,000-$99,999	1 (11.1%)
$100,000-$124,999	1 (11.1%)
ADHD diagnosis	
ADD/ADHD Inattentive Type	1 (22.2%)
ADHD Hyperactive/Impulsive Type	0 (0%)
ADHD Combined Type	6 (66.7%)
Don't know	1 (11.1%)
Mean age at first diagnosis (*SD*)	19.2 (*11.1*)
Diagnosed by	
Psychologist	6 (66.7%)
Psychiatrist	2 (22.2%)
Family doctor	1 (11.1%)
Neurologist	1 (11.1%)
Taking medication	
Yes	7 (77.8%)
No	2 (22.2%)
Other mental health condition	
Generalized Anxiety Disorder (GAD)	7 (77.8%)
Major Depressive Disorder	5 (55.5%)
Panic Disorder	1 (11.1%)
Dysthymia	1 (11.1%)
PTSD	1 (11.1%)
Trichotillomania	1 (11.1%)
Sensory Processing Disorder	1 (11.1%)
Remitted Opioid Use Disorder	1 (11.1%)
Borderline Personality Disorder	1 (11.1%)
Binge Eating Disorder	1 (11.1%)
Seeing a therapist or counselor?	
Yes	7 (77.8%)
No	2 (22.2%)
Hospitalized for mental health?	
Yes	2 (22.2%)
No	7 (77.8%)
Number of times hospitalized for mental health	
1 time	2 (22.2%)
N/A	77 (77.8%)
Attended in-person ADHD support groups	
Yes	0 (0%)
No	9 (100%)
Took part in online ADHD support groups	
Yes	1 (11.1%)
No	8 (88.9%)

Table 2. Demographics of Individual Participants of Final Sample

Participant	Age	Race	Marital Status	Employment	Student?	Highest Level of Education Completed	ADHD diagnosis (year)	Comorbid Conditions	Medication?	Therapist?	Hospitalized for Mental Health?
001	34	White	Married	Part-time	Yes	Bachelor's degree	Inattentive (2018)	PTSD & GAD	No	Yes	No
013	30	White	Cohabiting	Full-time	No	Graduate degree	ADD (1997)	GAD & Trichotillomania	No	Yes	No
015	27	White	Cohabiting	Full-time	No	Bachelor's degree	Combined (2011)	GAD	Yes	No	No
018	29	White	Cohabiting	Full-time	No	High school	Don't know (2006)	MDD & GAD*	Yes	Yes	No
011	25	White	Cohabiting	Unemployed	Yes	High school	Combined (2020)	MDD & GAD	Yes	Yes	Yes
004	33	White	Single	Full-time	No	Graduate degree	Combined (1993)	MDD & GAD	Yes	Yes	No
010	34	White	Cohabiting	Unemployed	No	High school	Combined (2002)	Dysthymia, Panic Disorder, Sensory Processing Disorder, Opioid Use Disorder (in remission)	Yes	Yes	Yes
020	45	White	Married	Unemployed	No	Bachelor's degree	Combined (2018)	MDD with anxiety	Yes	Yes	No
005	25	Black	Single	Unemployed	Yes	High school	Combined (2016)	GAD, MDD, BPD, Binge-Eating Disorder	Yes	No	No

*Participant 018 considers her anxiety to be a part of her ADHD and depression to be an incorrect diagnosis. Because these fit the criteria as diagnosed mental health conditions, they are included here with that caveat.

Table 3. Themes: Societal Expectations of Women (*n* = 9)

Category	Theme	Definition	n (%)	Quote
Roles/actions societally expected of women	Motherhood	Refers to being a biological mother and raising one or more children	7 (77.8%)	"I think society thinks that women all women are just going to be a mother, right that they're meant to be Mom. That's their quality, they're all meant to be caregivers. They can all do it perfectly without even trying." --Participant 006
	Homemaking	Refers to being a stay-at-home mom and taking care of one's children and the household while one's partner works	5 (55.6%)	"Well, I live in the Bible Belt… And so, a lot of people here still have the assumption that if you're going to have kids, then you're going to stay home and your husband is going to work." --Participant 020
	Marriage	Refers to being legally and (if applicably) religiously married to one's partner	4 (44.4%)	"In my culture, I'm an old lady right now, being 33 and single. All… the friends I grew up with, … they're all married and have, like, five kids." --Participant 004
	Professional Employment	Refers to having a job or career through which one supports herself and (if applicable) the members of her family	3 (33.3%)	"For men, the expectation is like, you have a career and you make money. And for women, now, it's all of the other things, plus you have a career and make money." --Participant 018
	Juggling	Refers to balancing multiple competing expectations, successful multitasking of a large number of disparate tasks	3 (33.3%)	"[The ideal woman is] superwoman, you know, the multi-tasker, but multitasking well. Truly juggling everything." --Participant 004

Qualities societally expected of women	Nurturing	Refers to nurturing and caring for others and putting others' needs first. Includes concepts such as taking one for the team; stepping up; and being a mothering or motherly figure (as opposed to an actual mother)	6 (66.7%)	"So, I'd say …we're seen as taking care of the group [as], you know, the mother figure or whatever it is." --Participant 015
	Organized	Includes being organized, focused, neat/tidy, taking care of logistics/planning, and keeping the household running	6 (66.7%)	"There's a lot of stuff that ends up falling on my shoulders, I think because, "Oh, well, you're a woman – you must be more organized," and I'm like, "I am not more organized than you." He's like, [Participant 018], where's our lease?" And I'm like, "Oh Jesus Christ…" --Participant 018
	Poised	Includes being poised/put together, meek/quiet, calm/passive, not fidgety/not impulsive	6 (66.7%)	"I think there are sometimes stereotypes about women, how they should be, maybe poised or meek." --Participant 001
	Lesser	Includes being less respected, less strong/athletic, less intelligent/more spacy, paid less	6 (66.7%)	"A lot of teenage male athletes will put other female athletes down. Just because, you know, they're girls, 'You can't run as fast, you can't do this.'" --Participant 020
	Nice	Includes being nice, social, emotional/empathetic, docile, a good listener, a pleaser	5 (55.6%)	"You know and I think there's also this idea of being nice. I think there's just such an expectation that we're going to have a smile on our faces and just be like, so thankful for everything." --Participant 018

Table 4. Themes: Participants' Own Qualities (n = 9)

Category	Theme	Definition	n (%)	Quote
Qualities Contradictory to Societal Expectations of Women	Not poised	Includes various qualities that contradict the expected category of being poised, including being loud/expressive (not quiet); active/rambunctious/fidgety/ impulsive (not calm/passive); and casual dress/little make-up (not put-together)	6 (66.7%)	"And here I am a little brazen, blurting things out, calling people out, talking a lot, wants to be, like, an active participant in the class and not just sitting and listening to somebody's lecture." --Participant 001
	Not organized	Includes various qualities that contradict the expected category of being organized (specifically, disorganized and low key/not a planner)	6 (66.7%)	"For the cooking, the cleaning… some days I can remember to do the basic stuff that I need to do, but some days I can't. And so, if everything isn't clean and up to par, or every meal isn't like a healthy cooked meal, that is not good… in society's eyes." --Participant 005
	Not nice	Includes various categories that contradict the expected quality of being nice, including not being nice, being intense and not docile; not being a pleaser; not being empathetic, and not being a good listener	4 (44.4%)	"I'm really bad at fake being super nice and bubbly. I've never been able to do that, and it's like I come off as mean, or not likable to people." --Participant 015
	Not lesser	Includes various qualities that contradict the expected quality of being lesser in various domains, including intelligent (not less intelligent); having high income (not paid less); and strong (not weak)	4 (44.4%)	"People … think that women … can't do an aggressive job, like being a police officer as efficiently, or being a firefighter as efficiently. And I definitely, like, firefighting was one of the biggest things that I was actually confident in. And so… when I was a firefighter, I was like, "No, I'm really good at this, like," and my peers that were my fellow firefighters all felt the same way." --Participant 011

	Not nurturing	Includes the quality of not being especially nurturing to others	2 (22.2%)	"[My boyfriend] honestly probably takes care of me more than I take care of him." --Participant 015
Qualities Consistent with Societal Expectations of Women	Nice	Includes being social, nice, emotional/empathetic, docile, a good listener, a pleaser; specifically refers in this context to being emotional and empathetic	2 (22.2%)	"The emotional aspect of it. My default response is usually crying, so if I get upset, if I get happy, I'll just cry." --Participant 010
	Nurturing	Refers to nurturing and caring for others and putting others' needs first	1 (11.1%)	"I was always the last kid to get picked up at school because both my parents worked really late hours…And I was like, I want to be a stay-at-home mom one day and be with my kids. So, I would say, definitely the nurturing piece. That's a big thing." --Participant 013
	Lesser	Includes being less respected, less capable in various respects; in this particular example it refers to being paid less income than men	1 (11.1%)	"…[I]n all of my jobs, I've actually gotten paid pretty poorly. But I don't know if that's … as an ADHD woman so much as it is a woman being paid poorly." --Participant 001

Additional qualities	One of the guys	Includes the qualities of being a tomboy or being seen/ experiencing oneself as "one of the guys"	2 (22.2%)	"[I] definitely don't fit into the normal standard of a woman. I fit in more of the category of, like, males like, I have a potty mouth. I cuss a lot. Like, I can tell crude jokes with the rest of them." --Participant 011
	Angry	Refers to experiencing or expressing anger more than is seen as societally typical	2 (22.2%)	"I think there's a lot more leeway [for men to get angry]. You know, it's just like, 'Oh, well, that guy gets angry sometimes,' whereas if I yell, it's a shock. It's shocking to people the first time. They get used to it, and then that makes it better, but…still." --Participant 018
	High expectations	Includes the qualities of having high expectations for oneself, wanting to prove oneself and being competitive	2 (22.2%)	"I don't know if this is ADHD - but I think sometimes my competitiveness could come across as ruthless, because I like to win… I can just be really competitive at just about anything, and I think sometimes that can be misunderstood just because I'm a woman." --Participant 020
	Tending toward extremes	Refers to an all-or-nothing quality in speech or action	2 (22.2%)	"In social situations, once I open the tap of me talking, it is very hard for me to shut it. Like, I have to either sit there very quietly and only literally speak what I'm spoken to, or I'm going to probably speak too much." --Participant 018

Table 5. Themes: Responses to Not Meeting Societal Expectations of Women (*n* = 8)

Category	Theme	Definition	n (%)	Quote
Thoughts & Feelings About Not Fitting Expectations	Self-acceptance	Refers to participants fully accepting themselves and preferring their own non-conforming qualities to qualities societally expected of women	2 (25%)	"It hasn't really bothered me that much. I've preferred to be how I am than be what they want me to be, I guess." --Participant 015
	Evolving views	Refers to participants changing their views on women's roles/qualities to come to a place of greater self-acceptance	2 (25%)	"So, I don't really feel like [my husband and I] fit in the stereotypical moulds. I'm actually okay with that now. I used to feel really uncomfortable with that." --Participant 001
	Ambivalence	Refers to participants experiencing conflicting feelings about not meeting expectations (for instance, being self-accepting on one level and self-critical on another).	2 (25%)	"So, I think inwardly, though, I still, hold myself to a lot of the same [societal expectations of women]. But I think just outwardly, I've just been like, 'No.' But I still judge myself for when I'm not fitting into the stereotype of how I'm supposed to be… even though other people think I don't judge myself." --Participant 018
	Frustration	Refers to participants being frustrated with themselves or with society's expectations as a result of not meeting those expectations	2 (25%)	"There's my initial feeling of I'm not living up to the expectation and I should. I'm not good enough because I am not doing that." --Participant 004

Actions Taken in Response to Not Fitting Expectations	Attempt to change self to conform to expectations	Refers to participants changing or attempting to change their natural way of being in order to meet societal expectations of women	3 (37.5%)	"Um, so some of those cultures I've been in… have a lot of pressure on being the homemaker, and so for several years, I actually tried to just be the homemaker, and I thought about giving up music entirely. I was depressed and miserable and kept finding other creative things to do. …[M]y life without music was miserable." --Participant 001
	Pretend to meet expectations	Refers to acting on the outside as if one conforms to a societal standard although one's inner reality is very different	3 (37.5%)	"So, I'm not a good listener… I'm very much empathetic, but not always. So, I will put on that face of, okay, this is how I'm supposed to react to the situation, because that's how I've been taught that somebody would react, or that's how other people have reacted to me. But I don't necessarily always have that emotional tie to the situation." --Participant 011
	Intentionally flout expectations	Refers to intentionally violating societal expectations. This can be out of confidence in one's own qualities or out of a feeling of despair about meeting societal expectations	3 (37.5%)	"I don't really mind. Like, I'd prefer not to [meet societal expectations]. Like, my boyfriend, he cooks the dinner, I clean everything, but he's the chef and he's the one that plans everything, and, you know, I'm not a planner either… And he honestly probably takes care of me more than I take care of him." --Participant 015

Table 6. Themes: Sources of Social Support (n = 9)

Category	Theme	Definition	n (%)	Quote
Family	Partner	Includes participants' partners, whether married or not	7 (77.8%)	"My husband [is a source of support], and I feel a lot closer to him, actually, in the last year, navigating all these things. I feel like we've had a lot more time to talk." --Participant 001
	Pets	Includes domestic animals who belong to the participants	5 (55.5%)	For sure, my dog, [Participant's dog]. If I'm getting stressed about something that's so minute and stupid, which I tend to do, I can be like, 'Okay, well, this is my animal and I need to feed him. We're giving him basic living requirements.' It seriously has helped me a lot." --Participant 015
	Children	Includes participants' biological children	4 (44.4%)	"My kids [are a source of support]. I feel like I've grown… in my affection and appreciation for them, especially with being around them more this year and letting go with my stereotypes of what I should be and look like." --Participant 001
	Parents	Refers to one or both of participants' biological parents	4 (44.4%)	"I mean, I would say, number one [source of social support] is my mom and my dad." --Participant 018
	Siblings	Includes one or more of participants' biological siblings	3 (33.3%)	"My sister's actually been like, my best friend for a long time." --Participant 010
	Other family	Includes other family members not previously mentioned such as in-laws and nieces/nephews	2 (22.2%)	"My husband's parents are kind of our family lifeline." --Participant 001

Friends	Local friends	Includes friends whom the participants know and see in person. It does not include friends with whom one associates as a result of work	6 (66.7%)	"Yeah, so I…have a really good friend that lives near me. We were friends in high school, and then we reconnected about seven or eight years ago. And she's my kids', they're my kids' God-parents." --Participant 020
	Long-distance friends	Includes friends with whom the participants connect virtually or by phone but who live too far away to see the participants regularly	4 (44.4%)	"And so, I've realized … that I actually have two or three friends. Unfortunately, they're not living in the state right now. They're somewhere else." --Participant 001
	Work friends	Includes friends with whom participants associate specifically through their work	2 (22.2%)	"I started a teacher social committee at my school, too. I'm like, I can't function if I don't have work friends... I have to have other people to lean on in this job. You just can't do it yourself. So, I started a little social club, and we try to do little events and stuff." --Participant 013
Mental Health and Medical Professionals	Therapists	Refers to psychologists or other mental health counselors whom participants see for therapy on a regular basis	9 (100%)	"For me, therapy is helpful because…there's no expectations for me, and I can share what I want to share in a safe environment." --Participant 020
	Doctors	Refers to psychiatrists specifically trained to treat mental health conditions, as well as family doctors	5 (55.6%)	"My psychiatrist is helpful in terms of, 'Hey, Doc, need a script,' right?" --Participant 018

Other	Other women with ADHD	Includes other women with ADHD with whom participants are socially connected, whether as friends, family, or religious or online community	7 (77.8%)	"It's validating… to realize I'm not a total weirdo. Then, also, [communicating with other women with ADHD] just kind of helps me realize what other things are ADHD-related that aren't widely talked about, and that's good…It's good in general knowing that I'm not alone." --Participant 005
	Online community	Includes individuals whom participants interact with only online and do not know outside of that context	5 (55.6%)	"I am part of a Facebook group called [Facebook group name], I don't know these people except for what they post." --Participant 007

Table 7. Themes: Level of Social Connectedness (n = 9)

Category	Theme	Definition	n (%)	Quote
Level of Social Connectedness	Less connected than ideal	Includes participant reports of being lacking in social connections relative to the number of social connections they would like to have.	7 (77.8%)	"That's always like a point of depression for me. I tend to feel like I'm not as connected as I want to be." --Participant 001
	Connected the right amount	Includes participant reports of being socially connected to the degree that they wanted to be, having neither too many nor too few connections	4 (44.4%)	"I feel satisfied. I feel good with [the amount of social connection I have]… I'm very content as I am. I'm very happy where I'm at." --Participant 010
	More connected than ideal	Includes participant reports of being in some respect more connected socially than they would like to be	3 (33.3%)	"And… for the last couple of years, I would say that I probably don't care to have so many [social connections]. I'd rather, you know, be more by myself." --Participant 004
Hypothetical Feelings If Connected the Right Amount	Happy/ Mentally healthy	Includes participants reports of feeling good, feeling positive, feeling joy, having improved mood, or feeling mentally healthier	6 (66.7%)	"It's huge. It makes my mood… just a lot better, I guess… I would be lost without the connections I have. I seriously don't know what I would do. So it's pretty big." --Participant 015
	Comfortable	Includes participants' reports of feeling comfortable, calm, and safe when connected the ideal amount	3 (33.3%)	"[I feel] safe, comfortable." --Participant 001
	Needs met	Includes participants reports of having their needs met/being taken care of or of being needed by others when they are connected the ideal amount	3 (33.3%)	It'll make me feel like my needs are met." --Participant 018

Table 8. Themes: Relationships Between ADHD & Social Connectedness (*n* = 9)

Category	Theme	Definition	n (%)	Quote
ADHD Effects on Social Connectedness	ADHD symptoms lead to a decrease in social connectedness	Includes participants' statements to the effect that having ADHD and/or experiencing more ADHD symptoms leads to or causes a decrease in social connectedness or support	7 (77.8%)	"My ADHD definitely affects how connected I am socially because I am the interrupting friend, I am the poor listener, I am the person who it is my way or the highway…" --Participant 011
	ADHD symptoms lead to an increase in social connectedness	Includes participants' statements to the effect that having ADHD and/or experiencing more ADHD symptoms leads to or causes an increase in social connectedness or support	2 (22.2%)	"I think [my ADHD] definitely helps me be able to connect better. … I love meeting new people and hearing new people's backgrounds and stuff. Like, I think it's super interesting. And I think my ADD kind of keeps me curious…" --Participant 015
No ADHD Social Connectedness Relationship	There is no relationship between ADHD and social connectedness	Includes participants' statements to the effect that there is no causal relationship in either direction between amount of social connectedness or support and severity of ADHD symptoms	1 (11.1%)	"No, I don't think [there is any connection between my level of social support and my ADHD symptoms]… I don't think… it's never negatively affected me, at least socially." --Participant 013

Social Connectedness Effects on ADHD	Social connectedness leads to a decrease in ADHD symptoms	Includes participants' statements to the effect that experiencing increased social connectedness or support leads to a decrease in ADHD symptoms	4 (44.4%)	"I would say that socializing has also affected my ADHD. It's helped in some regards because I've learned, I've met some people and I've got some really great tools out of it, and I've felt less alone, which was really important." --Participant 010
	Social connectedness leads to an increase in ADHD symptoms	Includes participants' statements to the effect that experiencing increased social connectedness leads to an increase in ADHD symptoms	2 (22.2%)	"[Level of social connectedness] kind of does [affect my ADHD symptoms]. When I don't socialize much, I can focus on stuff better. Let's say I'm socializing a lot, I feel like I'm trying to keep my mind focused on too much at one time and make sure everybody is happy, and it's overwhelming." --Participant 005
	Social connectedness above and below the optimal level leads to ADHD symptoms	Includes participants' statements to the effect that both too much and too little social connection makes ADHD symptoms worse, and there is an optimal level of social connection in between these two extremes	1 (11.1%)	"How connected I am socially, affects my ADHD because if I am in that state of over-connection with people socially, then I feel overwhelmed… Being under-connected definitely affects my ADHD because I don't have the social constructs that I need to really stay on task and really stay motivated…" --Participant 011

Table 9. Themes: Relationships Between ADHD & Comorbid Conditions (*n* = 9)

Category	Theme	Definition	n (%)	Quote
ADHD Effects on Comorbid Conditions	ADHD symptoms lead to an increase in comorbid symptomatology	Includes participants' statements to the effect that having ADHD and/or experiencing more ADHD symptoms leads to or causes an increase in comorbid symptomatology	9 (100%)	"I think my anxiety is a hundred percent a result of my ADHD." --Participant 018
No Relationship Between ADHD and Comorbid Conditions	ADHD symptoms do not influence comorbid symptomatology or vice versa	Includes participants' statements to the effect that there is no causal relationship in either direction between ADHD symptoms and the symptoms of comorbid conditions	3 (33.3%)	"I don't really think [ADHD] relates to binge-eating very much." --Participant 005
Comorbid Condition Effects on ADHD	Comorbid symptoms lead to an increase in ADHD symptomatology	Includes participants' statements to the effect that experiencing increased comorbid symptomatology leads to an increase in ADHD symptoms	2 (22.2%)	"I think that the anxiety also hurts my ADD symptoms." --Participant 015

Table 10. Themes: Relationships Between Comorbid Conditions & Social Connectedness (n = 9)

Category	Theme	Definition	n (%)	Quote
Comorbid Condition Effects on Social Connectedness	Comorbid symptoms lead to a decrease in social connectedness	Includes participants' statements to the effect that having one or more comorbid conditions and/or experiencing more comorbid symptoms causes a decrease in social connectedness	7 (77.8%)	"I would definitely say that anxiety leads to me… not connecting... I definitely struggle socially with anxiety. So, like, I don't want to reach out to people. [Laughs] So, that definitely plays a role in how socially connected I am." --Participant 011
Social Connectedness Effects on Comorbid Conditions	Social connectedness leads to a decrease in comorbid symptoms	Includes participants' statements to the effect that experiencing increased social connectedness leads to a decrease in comorbid symptomatology	8 (88.9%)	"When I socialize more, I feel less depressed." --Participant 005
	Social connectedness leads to an increase in comorbid symptoms	Includes participants' statements to the effect that experiencing increased social connectedness leads to an increase in comorbid symptomatology	6 (66.7%)	"But if I have too much [social connection], it starts making me feel like, 'Oh, my God, it's so much,' like, it starts making me anxious as well." --Participant 018
	Social connectedness above or below optimal level leads to comorbid symptoms	Includes participants' statements to the effect that both too much and too little social connection makes comorbid symptoms worse, and there is an optimal level of social connection in between these two extremes	3 (33.3%)	"I would say that under-connectivity definitely leads to more of a depressive episode. But over social connectivity leads more to anxiety. So, yeah, I think that it definitely does play a part. Same kind of thing, both ways if you're under or overconnected." --Participant 011

Table 11. Themes: Messages for Other Women with ADHD (*n* = 9)

Category	Theme	Definition	n (%)	Quote
Messages Encouraging Connection with Others	Know that you're not alone/your experience is valid	Includes participants' statements that other women with ADHD are not alone in their experience of the disorder and that their experience is valid	3 (33.3%)	"…[Y]ou're not alone, and there are some great things about [ADHD]." --Participant 001
	Seek support from others	Includes participants' statements encouraging other ADHD women to reach out to others around them for social support, and/or to seek external support and structure to cope with symptoms of ADHD	3 (33.3%)	"Get an ADHD coach, and pay for it, because it holds you responsible. So, even though you don't want to do the call on that day that you got the call, because you forgot to set an alarm for it, so you didn't realize it was going on, [you do the call]." --Participant 011
	Be open about your ADHD	Includes participants' statements encouraging other ADHD women to be open about, talk about, or make know their disorder to the general public	2 (22.2%)	"The more that we're actually open about our stuff, the better it will be. And it's sort of a thing where we all have to jump into this pool together." --Participant 018
Messages Encouraging Making the Best of Life with ADHD	Do your research	Includes participants' statements encouraging other ADHD women to study/do research on/learn about resources for ADHD	4 (44.4%)	"Do research on ADHD. Your own research. Join and read ADDitude magazine and all their articles that they put out there. They're super helpful." --Participant 011

Appreciate the gifts of ADHD	Includes participants' statements encouraging other women to appreciate the gifts, skills, or powers that they have as a result of ADHD	2 (22.2%)	"If you harness the actual powers of ADHD, you can do wonderful things. You can be creative. You can - if you know what lights your heart on fire, then you can just do great things with it." --Participant 010
Decide your own life direction	Includes participants' statements encouraging other ADHD women to choose their own direction in life and not be controlled by others' ideas of what they should do	2 (22.2%)	"I would say don't let other people's judgment of you change the direction that you want to take your life." --Participant 013
Stay in the present moment	Includes participants' statements encouraging other women with ADHD to stay focused on the present and not bring themselves down by wondering what life could had been with an earlier diagnosis	1 (11.1%)	"You have to stay in the present moment, because it is really hard to have that feeling of, 'I feel like I missed out on a whole life I could have [led], had I had the diagnosis, had I been treating this.' It's like, that doesn't matter. It's not bad. [Your life is] not over." --Participant 010

Table 12. Themes: Messages for the General Public (*n* = 9)

Category	Theme	Definition	n (%)	Quote
Requests of the General Public	Don't judge us/give us grace	Includes participants' requests that others not judge them or judge their efforts/performance less harshly	4 (44.4%)	"Give us a little bit more leeway. Understand that we have very good intentions…" --Participant 018
	Help us	Includes participants requests that others help and support them in effectively coping with their symptoms and accomplishing tasks	3 (33.3%)	"And so, those people with the crazy, creative ideas - embrace them, but help them. Help them filter, don't just put it all on them to do it. Help them prioritize." --Participant 001
	Don't discount us because we don't fit stereotypes	Includes participants' requests that others not discount their experience or view them as less feminine just because they don't fit societal stereotypes of women	2 (22.2%)	"I know I'm not the same as the social construct of what you think, like, women should be, but it doesn't make me any less of a woman..." --Participant 011
	Get better at diagnosing ADHD in women	Includes participants' statements to the effect that ADHD needs to be better understood and diagnosed in women specifically	2 (22.2%)	"…[hopefully] more people will be willing to acknowledge that maybe that child actually does have ADHD, vs. teachers only saying, "Maybe that boy should get checked for ADHD, not the girls." --Participant 005
	Know that it's not about you	Includes participants' request that others not take these women's struggles with ADHD personally	1 (11.1%)	"Stop taking everything so personally. My tardiness is not about you. It's not that I don't like my job, because I love my job. It's not that I, I don't want to be this appointment. It's just that I forgot." --Participant 010

Information for the General Public	Living with ADHD is painful/difficult	Includes participants' statements regarding difficulty, distress or negative emotions that are entailed in their experience of being a woman with ADHD	4 (44.4%)	"This isn't fun, this has been a struggle. It's definitely had its low points." --Participant 010
	We have strengths	Includes participants' statements that women with ADHD have strengths, particularly that they are creative and capable	3 (33.3%)	"I think that we're very capable of multitasking and being mothers and working and doing pretty much everything and also kind of have a unique perspective ADD gives us, just kind of thinking a little bit outside the box. And I think that we're much more capable than people probably would perceive us on paper." --Participant 015
	Women often hide their struggles with ADHD	Includes participants' statements about how they or women with ADHD generally tend to hide their struggles	3 (33.3%)	"Maybe [if ADHD in women were more widely acknowledged] there'd be less masking, girls trying to hide the problems that they're having and various things, because it would be more accepted socially." --Participant 005
	We exist	Includes participants' statements informing the public that women with ADHD exist or that their experience is real	2 (22.2%)	"My experience is real and it's valid and I would like others to respect that." --Participant 010