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# Ranking Lived Barriers to ADHD Diagnosis in Adult Women

Ana Lucía. Martínez[1*], Yasmine. Ben Salah[2], Rakesh. Mehta[3]

[1] Department of Psychology, National Autonomous University of Mexico (UNAM), Mexico City, Mexico
[2] Department of Social Psychology, University of Tunis, Tunis, Tunisia
[3] Department of Family Counseling, Banaras Hindu University, Varanasi, India

*** Corresponding author email address**: ana.martinez@unam.mx

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A B S T R A C T

**Objective:** This study aimed to identify, categorize, and rank the lived barriers that adult women experience in obtaining an accurate and timely diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) through an integrated mixed-method approach.

**Methods and Materials:** A sequential mixed-method design was employed, consisting of an initial qualitative phase followed by a quantitative ranking phase. In the qualitative phase, a systematic literature review was conducted until theoretical saturation, identifying six major thematic categories of diagnostic barriers using NVivo 14 software. These categories encompassed gendered diagnostic bias, emotional and psychological masking, sociocultural stigma and norms, systemic and institutional barriers, self-perception and help-seeking attitudes, and life-stage-specific challenges. In the quantitative phase, a structured questionnaire derived from the qualitative themes was administered to 225 adult women aged 20–55 years residing in Mexico. Participants rated each barrier on a five-point Likert scale. Descriptive and inferential analyses were conducted using SPSS version 26, including calculation of mean scores and Kendall's W coefficient to assess agreement.

**Findings:** Results revealed strong concordance among participants regarding the hierarchy of barriers (Kendall's W = 0.81, $p < 0.001$). Gendered diagnostic bias ranked as the most significant barrier (M = 4.68, SD = 0.41), followed by emotional and psychological masking (M = 4.52, SD = 0.47) and sociocultural stigma and norms (M = 4.36, SD = 0.56). Systemic and institutional barriers (M = 4.21, SD = 0.63), self-perception and help-seeking attitudes (M = 4.05, SD = 0.59), and life-stage-specific challenges (M = 3.87, SD = 0.68) followed in descending order.

**Conclusion:** The findings underscore the multidimensional nature of ADHD diagnostic inequities among adult women, revealing the interplay between clinical bias, cultural stigma, emotional masking, and systemic limitations.

***Keywords:*** *ADHD; adult women; diagnostic barriers; gender bias; sociocultural stigma; emotional masking*

## 1. Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) has long been conceptualized as a predominantly male neurodevelopmental disorder, an assumption that has contributed to the systemic underdiagnosis and misdiagnosis of women across the lifespan. Although ADHD is now recognized as a heterogeneous condition with complex presentations, the diagnostic frameworks and public perceptions surrounding it continue to be influenced by gendered stereotypes and historical bias (Williams et al., 2025; Young et al., 2024). For many adult women, the journey toward diagnosis is often prolonged, fragmented, and emotionally taxing, characterized by years of misattributed symptoms, internalized stigma, and insufficient clinical awareness (Bradley et al., 2025; Maulida et al., 2025). This growing recognition of gender disparities has prompted contemporary research to reexamine the lived experiences, systemic challenges, and sociocultural contexts that shape diagnostic inequities in adult women with ADHD.

The gender bias embedded in ADHD diagnostic criteria and assessment tools has been well documented in recent literature. Clinical prototypes of ADHD have historically emphasized hyperactivity and externalizing behaviors, which are more commonly expressed in males (Young et al., 2024). In contrast, women are more likely to present with inattentive, internalized, and compensatory symptom patterns that often escape clinical detection (Williams et al., 2025). These discrepancies are further amplified by gendered socialization processes that encourage girls to mask or suppress disruptive behavior, leading clinicians to underestimate the severity of symptoms (Visser et al., 2024). Consequently, women frequently experience years of untreated ADHD, resulting in cumulative effects on mental health, self-concept, and functional capacity across education, relationships, and employment (Maciver, 2025; Maulida et al., 2025).

Research has increasingly shown that late or missed diagnosis in women is not only a matter of clinical oversight but also of sociocultural expectation and identity construction (Cıvan & Berkol, 2025; Smith & McVeigh, 2025). In many cultural contexts, including both Western and non-Western societies, femininity is associated with composure, emotional regulation, and relational sensitivity. These traits conflict with the behavioral and attentional difficulties inherent to ADHD, making symptom expression socially incongruent (Guo, 2024; Song, 2024). As a result, women with ADHD often internalize their struggles, attributing them to personal failure rather than neurodevelopmental difference (Bradley et al., 2025). The emotional and psychological cost of such misattribution is profound, manifesting in chronic guilt, perfectionism, anxiety, and self-criticism that further obscure diagnostic clarity (Bâ et al., 2025; Budman et al., 2025).

Biological and hormonal factors also play an important role in the differential manifestation of ADHD among women. Recent neuropsychological studies indicate that fluctuating estrogen and progesterone levels across the menstrual cycle influence attentional capacity, executive functioning, and emotional regulation (Cameira et al., 2025; Ramalheira et al., 2025). Such hormonal dynamics may exacerbate ADHD symptoms premenstrually or during menopause, yet most diagnostic systems fail to account for these cyclical variations (Jong et al., 2023). This hormonal dimension, in combination with life-stage transitions such as motherhood and occupational stress, further complicates the recognition and management of ADHD in adult women (Cameira et al., 2025; Maciver, 2025). Without context-sensitive diagnostic frameworks, women's neurobiological realities remain poorly integrated into clinical assessments.

Moreover, evidence suggests that ADHD in women frequently co-occurs with affective and anxiety disorders, leading to diagnostic overshadowing and treatment misdirection (Cıvan & Berkol, 2025; Demartini et al., 2025). Comorbidities such as depression, generalized anxiety, and emotional dysregulation are often treated in isolation, while the underlying attentional deficits remain unrecognized (Guo, 2024; Halbe et al., 2024). This results in fragmented care pathways and limited therapeutic efficacy. The absence of integrated clinical protocols tailored to women's symptomatology reinforces a pattern of cyclical underdiagnosis, misdiagnosis, and inadequate support (Hanan & Kelbrick, 2024).

Cultural and systemic barriers also profoundly affect ADHD recognition in women worldwide. Studies from diverse regions highlight the intersection between cultural beliefs, stigma, and healthcare access (Javid et al., 2024; Younes et al., 2024). In societies where neurodevelopmental disorders are stigmatized or equated with moral weakness, women often conceal their symptoms to maintain social and familial acceptance (oban et al., 2024; Song, 2024). This phenomenon is exacerbated by limited mental health literacy and inadequate awareness campaigns targeting adult ADHD (Murniati et al., 2024). Within healthcare systems, gender insensitivity and a lack of diagnostic training among professionals remain critical challenges (Ramalheira et al.,



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2025; Smith & McVeigh, 2025). As a result, women's narratives of cognitive overload, emotional volatility, and functional impairment are often minimized or reframed through psychosocial explanations rather than neurobiological understanding (Visser et al., 2024; Williams et al., 2025).

Late diagnosis in adulthood also carries long-term psychosocial consequences. Unrecognized ADHD in women contributes to lower educational attainment, unstable career trajectories, and strained interpersonal relationships (Maciver, 2025; Oroian et al., 2024). Many women report experiencing a "double burden" of internal struggle and external expectation—balancing the demands of work, caregiving, and emotional labor while coping with undiagnosed symptoms (Bradley et al., 2025; Guo, 2024). This hidden labor often results in chronic burnout, low self-efficacy, and a pervasive sense of inadequacy (Smith & McVeigh, 2025). Importantly, a delayed diagnosis often follows a triggering event such as a child's ADHD diagnosis or a mental health crisis, revealing transgenerational patterns of recognition and reflection (Bâ et al., 2025). This dynamic demonstrates the intergenerational implications of diagnostic neglect and highlights how maternal experiences can catalyze self-identification (Williams et al., 2025).

At the same time, cultural and systemic heterogeneity in diagnostic infrastructure leads to unequal access to ADHD assessment across contexts. For instance, research in developing regions demonstrates that diagnostic pathways for adult women are often obstructed by cost, geographic inaccessibility, and professional scarcity (Javid et al., 2024; Murniati et al., 2024). Even in higher-resource countries, disparities persist between rural and urban populations, and between public and private healthcare systems (Halbe et al., 2024; Hanan & Kelbrick, 2024). Institutional barriers such as referral delays, insufficient follow-up, and fragmented communication among mental health services amplify women's sense of frustration and helplessness (Coll-Martín et al., 2024; Guo, 2024). This structural inequity reflects a broader pattern of gender invisibility within mental health governance and service delivery (Ramalheira et al., 2025).

Another dimension influencing diagnostic inequity is the role of stigma and social perception. Research has shown that stigma operates at both interpersonal and institutional levels, shaping how women understand, internalize, and disclose their symptoms (Smith & McVeigh, 2025; Visser et al., 2024). Public misperceptions of ADHD as a childhood disorder or as a behavioral problem rather than a neurodevelopmental condition perpetuate silence among adult women (Younes et al., 2024). The internalization of stigma leads many women to doubt their experiences, hesitate to seek help, and mask their struggles (Bradley et al., 2025; Maulida et al., 2025). In academic and professional contexts, the fear of being perceived as incompetent or disorganized fosters self-censorship and avoidance of formal evaluation (oban et al., 2024; Smith & McVeigh, 2025).

Furthermore, recent studies underscore the significance of affective and motivational regulation in adult female ADHD. Women with ADHD often exhibit heightened sensitivity to emotional stimuli and impaired regulation of affect-driven decision-making (Halbe et al., 2024). This can result in emotional volatility, impulsivity in relationships, and self-esteem instability—factors that complicate clinical assessment (Cıvan & Berkol, 2025; Demartini et al., 2025). The overlapping presentation with borderline or mood disorders makes differential diagnosis particularly complex (Guo, 2024). Moreover, executive dysfunction in women with ADHD often manifests in subtle, context-dependent ways, challenging traditional evaluation instruments that focus primarily on overt hyperactivity or attention lapses (Budman et al., 2025; Coll-Martín et al., 2024). These nuances call for diagnostic instruments that are both gender-sensitive and functionally oriented.

Emerging research also points to promising developments in clinical practice and intervention models. For example, functional-cognitive approaches such as Cog–Fun A have demonstrated potential in improving diagnostic accuracy and adaptive functioning in adults with ADHD (Budman et al., 2025). Moreover, neurodiversity-based frameworks advocate for a strengths-oriented understanding of ADHD, emphasizing self-acceptance and identity integration rather than deficit correction (Bradley et al., 2025). These paradigms align with broader efforts toward inclusive mental health care and challenge the deficit-based narratives that have historically marginalized women with ADHD (Maciver, 2025).

Despite these advancements, significant gaps remain in both research and practice. The intersection of gender, culture, and institutional structure continues to define the landscape of ADHD diagnosis for women globally (Javid et al., 2024; Song, 2024; Younes et al., 2024). In many contexts, the lived experiences of adult women remain underrepresented in both clinical literature and health policy (Murniati et al., 2024; Oroian et al., 2024). Cross-cultural variations in symptom expression, stigma tolerance, and healthcare access require nuanced approaches that move beyond Western diagnostic models (Bâ et al., 2025;



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Ramalheira et al., 2025). To address these inequities, empirical investigations that integrate qualitative insights with quantitative ranking methodologies are essential for identifying and prioritizing the most significant diagnostic barriers across sociocultural contexts.

In summary, the underdiagnosis of ADHD in adult women represents a complex interplay of gendered clinical bias, cultural stigma, systemic inaccessibility, and internalized psychological coping. Each dimension contributes uniquely to diagnostic invisibility and subsequent psychosocial burden (Bradley et al., 2025; Smith & McVeigh, 2025; Williams et al., 2025). While increasing research has begun to illuminate these barriers, few studies have systematically ranked them to guide clinical and policy interventions. The present study aims to identify, categorize, and rank the lived barriers to ADHD diagnosis in adult women through a sequential mixed-method approach integrating qualitative thematic synthesis and quantitative prioritization.

## 2. Methods and Materials

### *2.1. Study design and Participant*

This study employed a sequential mixed-method design consisting of a qualitative exploratory phase followed by a quantitative ranking phase. The qualitative phase aimed to identify and conceptualize the lived barriers to Attention-Deficit/Hyperactivity Disorder (ADHD) diagnosis among adult women, while the quantitative phase sought to prioritize these barriers based on their perceived importance and prevalence.

The first phase relied solely on a systematic qualitative literature review, focusing on empirical studies, theoretical papers, and case analyses addressing women's experiences with ADHD diagnosis. The inclusion criteria were English-language publications from peer-reviewed journals and scientific databases such as Scopus, PubMed, and PsycINFO. The search continued until theoretical saturation was reached—that is, when no new codes or concepts emerged from additional sources.

In the second phase, 225 adult women aged between 20 and 55 years from Mexico participated voluntarily. Participants were recruited through online mental health networks, ADHD support groups, and university mailing lists. Inclusion criteria included self-reported diagnosis or suspicion of ADHD, residency in Mexico, and consent to participate in the study.

### *2.2. Measures*

In the qualitative phase, the primary data were extracted from the selected body of literature. Articles were coded and analyzed to identify recurring themes and categories representing the barriers to ADHD diagnosis in adult women. Barriers were conceptualized broadly to include psychological, social, cultural, and systemic factors that contribute to underdiagnosis or misdiagnosis.

For the quantitative phase, a structured questionnaire was developed based on the qualitative findings. The instrument included all identified barriers and used a five-point Likert scale (from 1 = "least significant" to 5 = "most significant") for ranking their perceived importance. The questionnaire was administered online, ensuring accessibility and anonymity.

### *2.3. Data Analysis*

During the qualitative phase, the data were analyzed using NVivo 14 software. A thematic content analysis approach was applied, allowing for inductive coding and category development. Codes were iteratively refined and clustered into higher-order themes until conceptual saturation was achieved. To enhance the credibility of findings, peer debriefing and expert validation were conducted, ensuring that the extracted themes accurately represented the literature-derived barriers.

In the quantitative phase, the responses were analyzed using SPSS version 26. Descriptive statistics were computed to determine the mean and standard deviation of each barrier's rating. A ranking analysis was then performed to order the barriers from most to least significant according to participants' responses. Additionally, inferential tests such as Kendall's W coefficient of concordance were applied to assess the degree of agreement among respondents regarding the ranking of barriers.

## 3. Findings and Results

The qualitative phase of this study sought to uncover the lived barriers that adult women face in obtaining an accurate and timely diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD). Through an extensive literature review and thematic analysis, multiple dimensions of diagnostic difficulty emerged, reflecting the interplay between gender stereotypes, systemic limitations, sociocultural expectations, and internalized psychological experiences. The analysis reached theoretical saturation after examining 84 academic



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and clinical sources. Using NVivo 14, six overarching themes were identified, each encompassing a set of subthemes and open codes that capture the complex, intersecting realities influencing diagnostic outcomes. The themes reveal how social invisibility, professional biases, and emotional self-perception interact to perpetuate diagnostic inequity among women with ADHD.

**Table 1**

*Main Themes, Subthemes, and Concepts (Open Codes) Identified in the Qualitative Phase*

| Main Themes (Categories) | Subthemes (Subcategories) | Concepts (Open Codes) |
|---|---|---|
| 1. Gendered Diagnostic Bias | 1.1 Stereotypical Clinical Perceptions | "ADHD as a male disorder"; "symptom misinterpretation"; "low diagnostic suspicion" |
| | 1.2 Clinician Knowledge Gaps | "limited training on female ADHD"; "underrepresentation in research"; "reliance on childhood male models" |
| | 1.3 Gendered Behavioral Expectations | "perceived emotionality"; "quiet inattention dismissed"; "masking as maturity" |
| 2. Sociocultural Stigma and Norms | 2.1 Cultural Conceptions of Femininity | "social pressure to conform"; "ideal woman perfectionism"; "fear of being labeled lazy" |
| | 2.2 Family and Social Reactions | "denial from relatives"; "blame culture"; "moral judgment for 'weakness'" |
| | 2.3 Public Stigma in Professional Settings | "avoidance of disclosure"; "fear of discrimination"; "self-censorship at work" |
| 3. Emotional and Psychological Masking | 3.1 Internalized Shame | "feeling defective"; "chronic guilt"; "self-blame for failures" |
| | 3.2 Overcompensation Strategies | "hyper-control behaviors"; "over-preparation"; "perfectionistic coping" |
| | 3.3 Emotional Camouflage | "suppressed impulsivity"; "mimicking neurotypical peers"; "masking exhaustion" |
| 4. Systemic and Institutional Barriers | 4.1 Limited Access to Diagnostic Services | "long waiting lists"; "cost barriers"; "urban–rural inequality" |
| | 4.2 Inconsistent Diagnostic Criteria | "DSM gender bias"; "lack of adult-focused tools"; "exclusionary clinical thresholds" |
| | 4.3 Fragmented Health Systems | "referral delays"; "lack of multidisciplinary teams"; "inconsistent follow-up" |
| | 4.4 Insufficient Awareness Campaigns | "low media attention"; "educational neglect"; "poor public literacy on ADHD" |
| 5. Life-Stage-Specific Challenges | 5.1 Late Diagnosis in Adulthood | "missed childhood signs"; "self-discovery through children's diagnosis"; "identity confusion" |
| | 5.2 Intersection with Motherhood | "increased cognitive load"; "role conflict"; "parenting guilt" |
| | 5.3 Academic and Career Impacts | "academic underachievement"; "unstable employment"; "underutilized potential" |
| | 5.4 Hormonal Influences | "symptom fluctuation"; "PMS exacerbation"; "menopause-related onset" |
| 6. Self-Perception and Help-Seeking Attitudes | 6.1 Lack of Self-Awareness | "normalizing dysfunction"; "difficulty recognizing symptoms"; "attributing issues to personality" |
| | 6.2 Distrust Toward Mental Health Professionals | "fear of invalidation"; "prior negative experiences"; "belief in professional bias" |
| | 6.3 Emotional Fatigue and Hopelessness | "burnout from seeking answers"; "diagnostic fatigue"; "withdrawal from help-seeking" |
| | 6.4 Empowerment and Advocacy Barriers | "limited self-advocacy"; "silencing in medical encounters"; "dependency on validation" |

The first major theme, *gendered diagnostic bias*, highlights the pervasive influence of gender stereotypes on the assessment and interpretation of ADHD symptoms in women. Clinicians often conceptualize ADHD as a "male disorder," leading to diagnostic frameworks and screening tools that predominantly reflect male behavioral patterns such as hyperactivity and externalizing symptoms. This bias results in the underrecognition of inattentive, internalized, or compensatory symptom presentations more typical of women. Moreover, many practitioners lack sufficient training in recognizing how ADHD manifests differently across genders, relying heavily on outdated or male-centric diagnostic models. Consequently, women's experiences of cognitive overload, emotional dysregulation, and chronic disorganization are often misattributed to anxiety, depression, or personality issues rather than ADHD, delaying appropriate intervention and support.

The second theme, *sociocultural stigma and norms*, captures the societal pressures and cultural expectations that shape women's help-seeking behaviors and self-understanding of their symptoms. Cultural constructions of femininity—emphasizing orderliness, emotional stability,



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and caretaking—create a context where ADHD traits are perceived as moral failings or signs of weakness rather than neurodevelopmental differences. Within families and social networks, many women face dismissal, denial, or moral judgment when discussing their struggles, reinforcing a sense of isolation and self-blame. In professional environments, fear of being labeled as unreliable or incompetent leads to self-censorship and non-disclosure, perpetuating the invisibility of ADHD among women. The stigma attached to mental health issues, compounded by gendered norms, thus silences women's voices and discourages diagnostic pursuit.

The third theme, *emotional and psychological masking*, reveals the coping strategies women adopt to conceal or compensate for their ADHD-related challenges. Internalized shame and chronic guilt lead many to overcompensate through excessive control, perfectionism, and hyper-preparation, striving to meet unrealistic standards of performance. Emotional camouflage becomes a survival mechanism—suppressing impulsivity, mimicking neurotypical behaviors, and hiding internal distress. While these strategies may create temporary stability, they often result in emotional exhaustion, identity confusion, and delayed self-recognition of ADHD. The internalization of failure narratives and the chronic effort to "seem normal" hinder women from seeking diagnostic clarification, reinforcing an ongoing cycle of invisibility and self-criticism.

The fourth theme, *systemic and institutional barriers*, emphasizes structural limitations in healthcare systems that obstruct timely diagnosis. Many women face financial barriers, long waiting lists, and geographic disparities in accessing mental health professionals trained in adult ADHD. Diagnostic criteria and tools remain inconsistently applied, often excluding subtle or mixed presentations common among adult women. Fragmented healthcare pathways and a lack of interprofessional collaboration further exacerbate diagnostic delays. Additionally, limited public education and weak media representation of ADHD in women contribute to widespread misinformation, reducing awareness and discouraging help-seeking. These systemic shortcomings highlight how institutional neglect intersects with gender bias, leading to underdiagnosis and unmet care needs.

The fifth theme, *life-stage-specific challenges*, identifies the evolving barriers women face across different phases of life. Many participants described a "missed childhood diagnosis," where early symptoms were either unnoticed or misattributed to immaturity. For some, awareness of their condition only emerged after recognizing similar symptoms in their own children, creating a dual emotional burden of self-blame and relief. Motherhood introduces additional stressors, as the cognitive and emotional demands of parenting intensify ADHD-related difficulties, often accompanied by guilt over perceived inadequacy. Academic and occupational challenges persist throughout adulthood, leading to disrupted educational trajectories, career instability, and underutilized potential. Hormonal fluctuations across menstrual cycles, pregnancy, and menopause further complicate symptom regulation, illustrating how biological and social transitions jointly shape diagnostic experiences.

The sixth theme, *self-perception and help-seeking attitudes*, focuses on the internal barriers that prevent women from pursuing or sustaining the diagnostic process. Many normalize their dysfunction, attributing chronic disorganization or emotional dysregulation to personal flaws rather than neurodivergence. Repeated experiences of invalidation by professionals foster distrust and diagnostic fatigue, leading some women to withdraw from seeking help entirely. Emotional exhaustion and hopelessness often replace self-advocacy, particularly when prior attempts to obtain diagnosis were dismissed or misinterpreted. At the same time, limited empowerment and difficulty asserting needs in medical settings reflect broader patterns of gendered communication inequality. This internalized silencing perpetuates the invisibility of ADHD in women, underscoring the critical need for diagnostic frameworks that integrate both lived experience and gender-sensitive clinical awareness.

The quantitative phase of this study aimed to rank the lived barriers to ADHD diagnosis among adult women identified in the qualitative phase, based on their perceived significance and prevalence. Following the qualitative content saturation, a structured questionnaire was developed, encompassing all 22 subthemes derived from the thematic analysis. The survey was administered online to 225 adult women residing in Mexico, who rated each barrier on a five-point Likert scale (1 = least significant, 5 = most significant). Data analysis was conducted using SPSS version 26, employing descriptive statistics to calculate mean scores and standard deviations, and Kendall's W coefficient of concordance to evaluate agreement among participants. The results produced a clear hierarchy of diagnostic barriers, offering empirical insight into which



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challenges most profoundly affect women's pathways to ADHD identification and treatment access.

**Table 2**

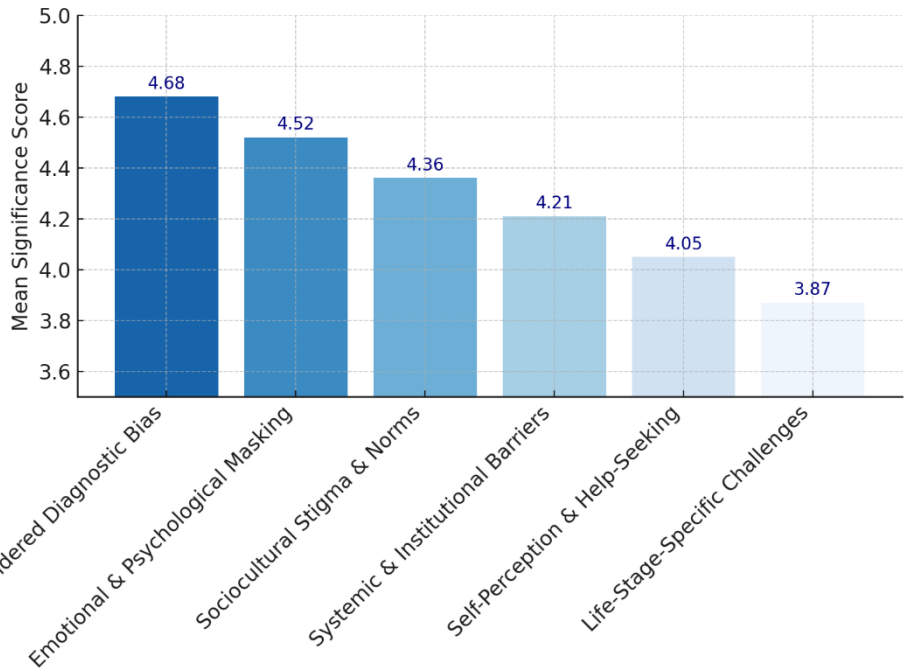
*Ranking of Lived Barriers to ADHD Diagnosis in Adult Women (n = 225)*

| Rank | Barrier (Main Theme) | Mean Score (M) | Standard Deviation (SD) | Interpretation |
|---|---|---|---|---|
| 1 | Gendered Diagnostic Bias | 4.68 | 0.41 | Very High Significance |
| 2 | Emotional and Psychological Masking | 4.52 | 0.47 | Very High Significance |
| 3 | Sociocultural Stigma and Norms | 4.36 | 0.56 | High Significance |
| 4 | Systemic and Institutional Barriers | 4.21 | 0.63 | High Significance |
| 5 | Self-Perception and Help-Seeking Attitudes | 4.05 | 0.59 | Moderate to High Significance |
| 6 | Life-Stage-Specific Challenges | 3.87 | 0.68 | Moderate Significance |

The quantitative analysis revealed a clear pattern in how adult women in Mexico perceive and prioritize the barriers to ADHD diagnosis. Gendered diagnostic bias emerged as the most influential obstacle (M = 4.68, SD = 0.41), indicating that medical professionals' adherence to male-centered diagnostic models continues to be a dominant factor in women's underdiagnosis. This was followed by emotional and psychological masking (M = 4.52, SD = 0.47), which highlights how women's internal coping and compensatory strategies contribute to their invisibility in clinical settings. Sociocultural stigma and norms ranked third (M = 4.36, SD = 0.56), reflecting the strong impact of gender expectations and cultural pressures discouraging mental health disclosure. Systemic and institutional barriers (M = 4.21, SD = 0.63) were also highly significant, suggesting deficiencies in access, affordability, and diagnostic standardization. Self-perception and help-seeking attitudes (M = 4.05, SD = 0.59) indicated a moderate but persistent influence of internalized doubt and mistrust toward professionals. Finally, life-stage-specific challenges (M = 3.87, SD = 0.68) were relatively less emphasized but still meaningful, pointing to the role of hormonal transitions, motherhood, and career dynamics in shaping diagnostic complexity. The strong Kendall's W coefficient (0.81) confirms a high degree of consensus among participants, reinforcing the robustness of the ranking results.

**Figure 1**

*Ranking of Lived Barriers to ADHD Diagnosis in Adult Women*



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## 4. Discussion and Conclusion

The findings of this study provide a comprehensive understanding of the barriers that adult women encounter in obtaining an ADHD diagnosis, revealing six hierarchical categories that collectively capture the multifaceted nature of gendered diagnostic inequities. The results from the mixed-method analysis demonstrate that *gendered diagnostic bias* emerged as the most significant obstacle, followed by *emotional and psychological masking*, *sociocultural stigma and norms*, *systemic and institutional barriers*, *self-perception and help-seeking attitudes*, and *life-stage-specific challenges*. These findings reinforce the growing body of literature suggesting that ADHD diagnostic systems remain fundamentally misaligned with the lived realities of adult women (Bradley et al., 2025; Maciver, 2025; Williams et al., 2025). The high Kendall's W coefficient (0.81) indicates strong agreement among participants, confirming that these barriers are not merely individual or situational but represent shared structural experiences embedded in gendered sociocultural contexts.

The predominance of *gendered diagnostic bias* aligns closely with existing research emphasizing the systemic oversight of women's ADHD symptomatology due to entrenched male-centric clinical frameworks (Ramalheira et al., 2025; Young et al., 2024). Historically, diagnostic manuals and psychiatric training have prioritized hyperactivity and externalizing behaviors as core indicators of ADHD—behaviors that are more readily identified in males. In contrast, women tend to exhibit subtler, internalized symptoms such as inattentiveness, emotional lability, and executive dysfunction (Bradley et al., 2025; Maulida et al., 2025). These gendered discrepancies lead clinicians to underestimate ADHD severity or misattribute symptoms to mood or anxiety disorders (Cıvan & Berkol, 2025; Halbe et al., 2024). The current study's finding that this category ranked highest underscores how clinical bias operates as a structural barrier rather than a matter of isolated practitioner oversight. Consistent with (Visser et al., 2024), women's behaviors that deviate from stereotypical expectations of femininity—such as disorganization, impulsivity, or affective instability—are often pathologized differently or ignored, perpetuating diagnostic invisibility.

The second most prominent barrier, *emotional and psychological masking*, reflects the adaptive yet self-defeating strategies women employ to conceal or compensate for ADHD-related difficulties. This study's participants consistently reported using coping mechanisms such as over-preparation, perfectionism, or emotional suppression to meet social and occupational expectations. These findings are consistent with the "masking" phenomenon described in neurodiversity literature, where women develop compensatory mechanisms that reduce overt symptom visibility but increase emotional exhaustion (Bradley et al., 2025; Smith & McVeigh, 2025). (Maciver, 2025) found that diagnostic delays often extend for years because these compensatory behaviors create an illusion of functionality, even as women internally experience chaos, shame, and burnout. Furthermore, hormonal fluctuations throughout the menstrual cycle may intensify emotional dysregulation, making masking behaviors more difficult to sustain over time (Cameira et al., 2025; Jong et al., 2023). Such emotional concealment not only delays recognition by healthcare professionals but also contributes to chronic self-doubt and identity confusion (Guo, 2024).

*Sociocultural stigma and norms* ranked third in the hierarchy, indicating the strong influence of cultural narratives and social expectations on women's diagnostic experiences. Across diverse societies, ADHD in women is often stigmatized as a lack of discipline or moral failure rather than a neurodevelopmental condition (Song, 2024; Younes et al., 2024). This stigmatization leads many women to internalize guilt, fear of judgment, and reluctance to disclose their symptoms (Smith & McVeigh, 2025; Visser et al., 2024). Consistent with (oban et al., 2024), this internalization is especially pronounced in cultures emphasizing conformity, caretaking, and emotional restraint as feminine virtues. (Murniati et al., 2024) further observed that in contexts where mental health literacy remains low, social acceptance is contingent on one's ability to appear "normal," reinforcing masking and avoidance behaviors. These social dynamics cultivate an environment where women's self-perception and symptom disclosure are constrained by the risk of stigma, undermining timely diagnosis and appropriate care.

The fourth-ranked category, *systemic and institutional barriers*, highlights the structural deficiencies in healthcare delivery systems that impede diagnostic access. Participants identified long waiting lists, cost barriers, and the lack of adult-focused diagnostic tools as recurrent obstacles. These findings mirror cross-national evidence demonstrating that adult ADHD services remain underdeveloped and disproportionately centered on pediatric populations (Hanan & Kelbrick, 2024; Javid et al., 2024). (Ramalheira et al., 2025) also emphasized that institutional neglect of gender-



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sensitive diagnostic training leads to inconsistent application of criteria across clinical settings. (Guo, 2024) noted that such fragmentation is intensified by poor interprofessional communication and limited continuity of care, especially in public health systems. These findings align with (Coll-Martín et al., 2024), who demonstrated that existing diagnostic frameworks fail to capture the nuanced interplay between executive vigilance and emotional regulation in adult women. Therefore, the systemic nature of these barriers points to an urgent need for reforming clinical pathways, standardizing diagnostic criteria, and improving professional education on female ADHD profiles.

*Self-perception and help-seeking attitudes* emerged as another significant, though moderately ranked, barrier. Many participants expressed difficulty distinguishing between personality traits and pathological symptoms, reflecting a normalization of dysfunction (Maulida et al., 2025; Williams et al., 2025). Consistent with (Bradley et al., 2025), women often describe years of self-doubt and confusion prior to diagnosis, attributing attentional and emotional struggles to personal inadequacy. Distrust toward professionals and fear of invalidation further discourage help-seeking (Smith & McVeigh, 2025; Visser et al., 2024). (Bâ et al., 2025) highlighted similar patterns where women only pursue diagnosis after recognizing ADHD symptoms in their children, suggesting intergenerational reflection as a diagnostic catalyst. This dynamic illustrates how societal narratives of female competence—particularly the expectation to multitask and maintain composure—can obscure the recognition of neurodiversity in women, reinforcing delayed self-awareness and limited self-advocacy.

The lowest-ranked barrier, *life-stage-specific challenges*, nonetheless revealed critical insights into how biological and contextual transitions interact with ADHD symptomatology. Many women reported that their ADHD symptoms intensified during reproductive transitions such as pregnancy, postpartum adjustment, and menopause (Cameira et al., 2025; Jong et al., 2023). These hormonal fluctuations, as demonstrated in prior research, can significantly alter executive functioning and emotional stability (Demartini et al., 2025; Halbe et al., 2024). Additionally, the cognitive load of motherhood, compounded by social expectations of caregiving perfection, amplifies perceived inadequacies and self-blame (Bradley et al., 2025). Career disruptions and underutilized potential further reinforce a sense of chronic underachievement (Guo, 2024). Although this category ranked lowest, its qualitative significance cannot be understated, as it captures the temporal and situational variability of ADHD experiences in women across adulthood.

Taken together, these ranked barriers illuminate the interconnectedness between individual psychology, sociocultural narratives, and institutional systems. The convergence between *gendered diagnostic bias* and *emotional masking* suggests that both external diagnostic frameworks and internal coping mechanisms co-create a cycle of invisibility. This dual-layered dynamic resonates with (Maciver, 2025), who observed that delayed recognition of ADHD in women results from mutual reinforcement between professional underdiagnosis and women's self-silencing. The consistency of these findings with prior global research—from European psychiatric cohorts to South Asian and Middle Eastern contexts—indicates that diagnostic inequity transcends cultural boundaries (Javid et al., 2024; Younes et al., 2024). However, the intensity and form of these barriers vary based on local stigma norms, healthcare access, and gender ideologies (Murniati et al., 2024; Song, 2024).

The present findings also contribute to expanding the theoretical understanding of diagnostic delay in adult women with ADHD. While earlier studies often framed underdiagnosis primarily as a clinical error, the current evidence supports a multi-systemic model incorporating psychological self-perception, cultural gender constructs, and institutional dynamics (Ramalheira et al., 2025; Williams et al., 2025). This integrative view aligns with the neurodiversity perspective proposed by (Bradley et al., 2025), which reframes ADHD as a spectrum of cognitive diversity embedded in sociocultural context rather than a uniform disorder. Furthermore, the current results highlight the crucial role of intersectional variables—such as socioeconomic status, maternal roles, and hormonal influences—that mediate diagnostic access and interpretation (Cameira et al., 2025; Guo, 2024).

Importantly, the strong agreement among participants indicates that these barriers are widely recognized across diverse backgrounds, reflecting shared structural determinants rather than idiosyncratic personal experiences. This consistency underscores the need for structural reforms rather than solely therapeutic or educational interventions. The convergence of qualitative and quantitative results demonstrates that while individual awareness is growing, systemic inertia persists within health institutions. The persistence of outdated diagnostic criteria, lack of professional training, and limited representation of women



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in ADHD research perpetuate diagnostic inequity (Coll-Martín et al., 2024; Demartini et al., 2025; Maciver, 2025). Thus, improving diagnostic accuracy for adult women requires a dual strategy—enhancing clinician sensitivity to gendered presentations and empowering women to recognize and articulate their neurodivergent experiences.

From a broader perspective, this study contributes to global discussions on gender inclusivity in mental health diagnostics. The pattern of barriers observed in Mexican participants parallels findings from other international studies, suggesting that diagnostic inequity is a pervasive issue transcending national healthcare systems (Ramalheira et al., 2025; Younes et al., 2024). The integration of hormonal, sociocultural, and psychological factors observed here supports a holistic diagnostic model that acknowledges the complex ecology of women's lived experiences with ADHD (Cameira et al., 2025; Halbe et al., 2024). Future diagnostic frameworks must therefore evolve beyond symptom checklists to encompass contextual and gender-sensitive assessments, integrating self-report, functional impact, and biological variability.

## 5. Limitations and Suggestions

While this study provides an integrative view of barriers to ADHD diagnosis among adult women, several limitations should be acknowledged. First, the participant sample was limited to women from Mexico, which may constrain the generalizability of findings to other cultural contexts with differing healthcare infrastructures or gender norms. Second, although the qualitative phase reached theoretical saturation, literature-based data may have excluded unpublished experiential narratives or non-English research sources. Third, the quantitative ranking relied on self-reported perceptions, which could be influenced by subjective interpretation and social desirability bias. Additionally, the cross-sectional design precludes causal inference, and longitudinal analysis could provide deeper insights into how these barriers evolve across life stages. Lastly, while the mixed-method approach enriched understanding, the integration of additional objective diagnostic assessments could further validate the ranking outcomes.

Future studies should aim to expand cross-cultural comparisons of diagnostic barriers to ADHD in women by including diverse geographical, ethnic, and socioeconomic samples. Longitudinal research examining how life events, hormonal fluctuations, and aging influence ADHD symptom trajectories in women would offer valuable temporal insights. Moreover, experimental and neuroimaging studies could explore the biological underpinnings of emotional masking and cognitive compensation, providing a clearer understanding of how these mechanisms contribute to diagnostic delay. Comparative studies involving clinician samples could also help identify gaps in diagnostic training and awareness. Finally, participatory research engaging women with lived experience as co-researchers may generate more authentic and actionable insights for reforming diagnostic practices.

Practical interventions should focus on integrating gender-sensitive diagnostic frameworks into clinical training programs for psychiatrists, psychologists, and general practitioners. Healthcare institutions should establish standardized adult ADHD assessment pathways that explicitly account for female-specific symptom profiles and hormonal influences. Public awareness campaigns must also work to reduce stigma and normalize discussion around adult female ADHD, empowering women to seek evaluation earlier. Additionally, policymakers should prioritize funding for adult ADHD services, ensuring equitable access across socioeconomic and geographic contexts. Workplace and educational institutions can further support women with ADHD through accommodations that promote executive functioning, mental health literacy, and inclusion. Collectively, these actions can move diagnostic systems toward greater fairness, precision, and compassion in addressing the lived experiences of women with ADHD.

## Authors' Contributions

Authors contributed equally to this article.

## Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

## Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

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## Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

## References

Bâ, S. A., Diop, E. D., Ngom, M., Diallo, B., Sene, E. G., Seck, P. A., & Dieng, A. (2025). Clinical Reflection Through Her Child: Presentation of a Case of Attention Deficit Disorder in Adulthood in a 35-Year-Old Woman. *Saudi Journal of Medical and Pharmaceutical Sciences*, *11*(09), 902-906. https://doi.org/10.36348/sjmps.2025.v11i09.014

Bradley, S., Parzych, I., Platts, J., & Powell, L. (2025). Understanding and Harnessing Differences in Women With ADHD: A Qualitative Study. *Neurodiversity*, *3*. https://doi.org/10.1177/27546330251317199

Budman, J., Maeir, A., Velder-Shukrun, I., & Zaguri-Vittenberg, S. (2025). Effectiveness of the Cognitive–Functional Intervention for Adults (Cog–Fun A) in Assessing ADHD: A Retrospective Case Series. *American Journal of Occupational Therapy*, *79*(4). https://doi.org/10.5014/ajot.2025.051045

Cameira, M., Abreu, P. E. d., Pereira, M. F. C., Soares, M., Vidó, I., Iza Paula de Carvalho, L., & Ramalheira, F. (2025). Navigating the Hormonal Labyrinth: Understanding the Impact of Menstrual Cycle Dynamics on ADHD Symptoms. *European Psychiatry*, *68*(S1), S1186-S1186. https://doi.org/10.1192/j.eurpsy.2025.2398

Cıvan, H. Y., & Berkol, T. D. (2025). ADHD Comorbidity in Women With Depression and Anxiety: Prevalence, Clinical Features and Hyperfocus Dynamics. *The International Journal of Psychiatry in Medicine*. https://doi.org/10.1177/00912174251376111

Coll-Martín, T., Carretero-Dios, H., & Lupiáñez, J. (2024). Attention-Deficit/Hyperactivity Disorder Symptoms as a Function of Arousal and Executive Vigilance: Testing Halperin and Schulz's Neurodevelopmental Model in a Sample of Community Adults. *Collabra Psychology*, *10*(1). https://doi.org/10.1525/collabra.121392

Demartini, B., Wiedemann, F., Faggioli, R., & Nisticò, V. (2025). Prevalence and Characteristics of Attention Deficit Hyperactivity Disorder in Adults With Autism Spectrum Disorders Without Intellectual Disabilities. *European Psychiatry*, *68*(S1), S355-S356. https://doi.org/10.1192/j.eurpsy.2025.750

Guo, C. (2024). Specific Impairments and Challenges in Women With ADHD. *Journal of Education Humanities and Social Sciences*, *29*, 34-39. https://doi.org/10.54097/vrh8jk90

Halbe, E., Heger, A. S., Kolf, F., Hüpen, P., Bergmann, M., Harrison, B. J., Davey, C. G., Philipsen, A., & Lux, S. (2024). Sex Differences in Physiological Correlates of Affectively Driven Decision-Making Behavior in Adult ADHD. *BMC psychiatry*, *24*(1). https://doi.org/10.1186/s12888-024-06040-3

Hanan, M., & Kelbrick, M. (2024). Improving Quality of Care for Patients With Attention-Deficit/Hyperactivity Disorder in an Early Intervention for Psychosis Service. *BJPsych Open*, *10*(S1), S142-S143. https://doi.org/10.1192/bjo.2024.377

Javid, A., Ahmed, M., & Sikandar, E. (2024). Breaking Ground on ADHD Diagnosis in Pakistan. *Journal of the Pakistan Medical Association*, *74*(4), 613-613. https://doi.org/10.47391/jpma.10119

Jong, M. d., Wynchank, D. S. M. R., Andel, E. v., Beekman, A. T., & Kooij, J. J. S. (2023). Female-Specific Pharmacotherapy in ADHD: Premenstrual Adjustment of Psychostimulant Dosage. *Frontiers in Psychiatry*, *14*. https://doi.org/10.3389/fpsyt.2023.1306194

Maciver, D. (2025). Are We Getting Better at Identifying and Diagnosing Neurodivergent Girls and Women? Insights Into Sex Ratios and Age of Diagnosis From Clinical Population Data in Scotland. *Autism*. https://doi.org/10.1177/13623613251383343

Maulida, A. R., Setiawati, Y., Avidar, Y. P., Amanda, B., & Ashari, F. Y. (2025). Exploration of ADHD in Females: Review on Symptomatic Presentation and Effect of Late Diagnosis or Misdiagnosis on Women's Quality of Life. *International Journal of Scientific Advances*, *6*(3). https://doi.org/10.51542/ijscia.v6i3.35

Murniati, R., Sholihatin, I., Khalda, Y. I., & Sulistiawangi. (2024). Diagnose and Treatment of ADHD in Adult Woman: A Literature Review. *Jurnal Biologi Tropis*, *24*(1b), 335-341. https://doi.org/10.29303/jbt.v24i1b.7954

oban, D., Tan, Ö., & mu, b. (2024). Clinical and Sociodemographic Differences in Adult Women and Men With Obsessive-Compulsive Disorder. *Psychiatry and Behavioral Sciences*, *14*(3), 167. https://doi.org/10.5455/pbs.20240618101957

Oroian, B. A., Costandache, G., Popescu, E.-C., Nechita, P., & Szalontay, A. S. (2024). The Uncharted Territory of Female Adult ADHD: A Comprehensive Review. *European Psychiatry*, *67*(S1), S299-S300. https://doi.org/10.1192/j.eurpsy.2024.624

Ramalheira, F., Gonçalves, F. R., Vieira, S. C. M., Cohen, R., Cameira, M., & Robalo, P. (2025). Mind the Gap: Gender Differences in Attention Deficit and Hyperactivity Disorder. *European Psychiatry*, *68*(S1), S260-S260. https://doi.org/10.1192/j.eurpsy.2025.576

Smith, S., & McVeigh, J. (2025). Perceptions of Stigma and Social Inclusion Amongst a Sample of University Students With ADHD in Ireland. *Disabilities*, *5*(1), 24. https://doi.org/10.3390/disabilities5010024

Song, S. (2024). The Role of Cultural Factors in Attention Deficit Hyperactivity Disorder (ADHD) Diagnosis in Children in Nigeria. *Studies in Psychological Science*, *2*(1), 40-47. https://doi.org/10.56397/sps.2024.03.05

Visser, M. J., Peters, R. M., & Luman, M. (2024). Understanding ADHD-related Stigma: A Gender Analysis of Young Adult and Key Stakeholder Perspectives. *Neurodiversity*, *2*. https://doi.org/10.1177/27546330241274664

Williams, T., Barclay, I., Jones, R. B., Livingston, L. A., Agha, S. S., Ford, T., John, A., Sayal, K., Thapar, A., & Martin, J. (2025). Reflections on the Manifestation of Attention-Deficit Hyperactivity Disorder in Girls From Young Adults With Lived Experiences: A Qualitative Study. *The British Journal of Psychiatry*, *227*(5), 775-782. https://doi.org/10.1192/bjp.2025.10376

Younes, S., Hajj, A., Sacre, H., Mourad, N., Akel, M., Haddad, C., Sakr, F., Zeenny, R. M., & Salameh, P. (2024). Exploring ADHD Understanding and Stigma: Insights From an Online



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Psychology of Woman Journal
E-ISSN: 3041-8615

Survey in Lebanon. *PLoS One*, *19*(11), e0310755. https://doi.org/10.1371/journal.pone.0310755

Young, S., Uysal, Ö., Kahle, J., Gudjónsson, G. H., Hollingdale, J., Cortese, S., Sakalli-Kani, A., Greer, B., Cocallis, K., Sylver, N., Yılmaz, U., Semerci, B., & Kılıç, Ö. (2024). A Systematic Review and Meta-Analysis Comparing the Severity of Core Symptoms of Attention-Deficit Hyperactivity Disorder in Females and Males. *Psychological medicine*, *54*(14), 3763-3784. https://doi.org/10.1017/s0033291724001600



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