EXPLORING THE LIVED EXPERIENCES OF BLACK WOMEN WITH UNDIAGNOSED ADHD UNTIL ADULTHOOD: AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS

by

LYNELL MELRA WILLIAMS

(Under the Direction of Amanda Giordano)

ABSTRACT

Despite growing recognition of Attention-Deficit/ Hyperactivity Disorder (ADHD) in women, Black women remain significantly underrepresented in research and clinical understanding of the disorder, often leading to delayed diagnosis and inadequate treatment. This study explored the lived experience of Black women who remained undiagnosed with ADHD until adulthood to understand how they made meaning of their experiences and the impact of receiving a delayed diagnosis. Drawing from both Intersectionality theory and Black Feminist Thought, this research centered the voices of Black women to understand how undiagnosed ADHD impacts their experiences across multiple life domains. Using Interpretive Phenomenological Analysis (IPA), ten Black women between the ages of 31-51 who received their ADHD diagnosis as adults (between ages 29-50) participated in semi-structured interviews focusing on their experiences with undiagnosed symptoms, self-concept, and the meaning of their diagnosis. Six themes were identified: (1) Misattributing Undiagnosed Symptoms to Identity, (2) Navigating the Pressure to Meet Impossible Standards, (3) Developing Complex Strategies to Cope, (4) Overlooking ADHD Due to Cultural and Social Misconceptions (with subtheme: Normalcy of ADHD Traits Within Family Dynamics), (5) Fighting to Be Heard, and (6) Grieving the Loss of Missed Opportunities. These findings revealed how race and gender influenced ADHD presentation, recognition, and diagnosis, highlighting the need for culturally responsive assessment and treatment approaches. This study addressed critical gaps in counseling literature by examining the intersection of race, gender, and mental health and advocated for improved mental health literacy and earlier intervention to reduce disparities in ADHD diagnosis among Black women.

INDEX WORDS: Attention-Deficit/Hyperactivity Disorder, Black women, interpretative phenomenological analysis, intersectionality, late diagnosis, mental health disparities

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DEDICATION

This dissertation is dedicated to all the amazing brilliant Black women with ADHD who are doing the damn thing. To my participants who were so vulnerable and open to sharing their lived experiences, I am forever grateful and forever inspired. To all of the amazing Black women who were even interested in participating in my study, I am overwhelmed in the best way possible. You all have continued to show me why this work is so important. There were so many times I questioned if this topic was needed or if it would even be accepted, and in the moments that mattered most you all reminded me that this was the exact topic that needed my attention. You remind me that our voice matters. You remind me that if we don't take an interest in ourselves as Black women, who else will? So, I stand 10 toes down for each and every one of you. I thank you all for supporting me, even in the smallest of ways. I have been touched and influenced by Black women I do not personally know, and yet I am forever changed and am a better woman because of it.

As Black women, my hope is that we get to be as successful as we want and as soft as we want. That we learn that rest is productive, and it does not have to be earned. That we learn to take our worth out of our work even though the world may say otherwise. That we are able to find safe spaces to unmask and show our authentic, quirky, fast-talking, fast-thinking selves, and even if they don't accept us, WE accept us. You were worth all of this work, and I dedicate it to you.

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CHAPTER 1

INTRODUCTION

This chapter sets the foundation for this study designed to explore the lived experiences of Black women who remained undiagnosed with Attention-deficit/hyperactivity disorder (ADHD) until adulthood. The chapter begins by examining how the intersection of race, gender, and mental health can create unique challenges for Black women in receiving timely ADHD diagnoses. The critical gaps in current research regarding Black women's experiences with undiagnosed ADHD are presented through the statement of the problem, followed by the purpose of the study, and guiding research question. The chapter then discusses the significance of this research for counselor education, clinical practice, and the development of culturally responsive interventions. A brief overview of the study's methodology and theoretical framework is also described to detail how the experiences of Black women with late ADHD diagnoses will be centered and explored. The chapter ends with definitions of key terms essential to understanding the study's context and focus.

Introduction

ADHD is a neurodevelopmental condition marked by persistent patterns of inattention, hyperactivity, and impulsivity that significantly disrupt everyday functioning (American Psychiatric Association [APA], 2013). Although ADHD symptoms typically present in childhood, many individuals, particularly those from marginalized populations, remain undiagnosed until adulthood (Waite, 2007). This delay in diagnosis can carry serious implications, affecting mental health, academic performance, career progression, and overall quality of life (Quinn & Madhoo, 2014). In specific, Black women may experience distinct challenges with a delayed ADHD diagnosis, facing unique barriers at the intersections of race, gender, and mental health, which can further complicate their experiences (Crenshaw, 1991; Waite & Ramsay, 2010).

The experience of living with undiagnosed ADHD presents unique challenges for Black women that differ significantly from both White women and Black men (Mays et al., 2007). Through the theory of Intersectionality, Crenshaw (1991) emphasized how multiple marginalized identities create distinct experiences of oppression that cannot be understood by examining race or gender separately. For Black women with undiagnosed ADHD, these intersecting identities may shape their experiences through the complex interplay of cultural expectations, systemic barriers, and societal pressures they face daily. For instance, symptoms of ADHD in Black women may be dismissed or misattributed to personality traits, leading to missed opportunities for early intervention and support (Waite & Ramsay, 2010). The Strong Black Woman schema (SBW), which emphasizes resilience and self-reliance, can further complicate the recognition and acknowledgment of ADHD symptoms, as Black women may feel pressure to maintain an image of strength while struggling silently with executive functioning challenges (Watson-Singleton et al., 2019).

Moreover, cultural and systemic barriers can contribute to the delayed diagnosis of ADHD in Black women. These barriers include limited access to culturally competent mental health providers, financial costs, and deep-rooted mistrust of healthcare systems stemming from historical and ongoing discrimination (Jones et al., 2014). Controlling images and stereotypes about Black women, such as the “Angry Black Woman” or assumptions about intelligence and capability, also can lead to misinterpretation of ADHD symptoms or dismissing legitimate concerns expressed by Black women (Lewis et al., 2016).

The impact of living with undiagnosed ADHD can affect multiple domains of Black women's lives. For instance, research indicates that undiagnosed ADHD can have detrimental consequences on Black women's academic and professional outcomes, often resulting in lower educational attainment and fewer job opportunities (Fletcher, 2014). Additionally, the intersection of untreated ADHD symptoms and racial discrimination can create compounded barriers to professional advancement and financial stability (Abramovitz & Zelnick, 2021). Furthermore, in interpersonal relationships, undiagnosed ADHD can lead to difficulties with communication and forming and maintaining connections (Holthe & Langvik, 2017; Zambo, 2008), challenges that may be further complicated by cultural expectations and stereotypes of Black women (Attoe & Climie, 2023). These instances illustrate how mental health challenges are often heightened by gendered racism, which can limit Black women's access to appropriate mental health care and support services (Lewis et al., 2017) and increase their risk of misdiagnosis and inadequate treatment (Waite & Ivey, 2009). Without proper diagnosis and treatment, many Black women may develop compensatory strategies that, while potentially helpful in the short term, may contribute to diminished self-esteem, increased stress, anxiety, and burnout over time (Holthe & Langvik, 2017). These compounding challenges highlight the critical need to understand how undiagnosed ADHD uniquely impacts Black women's lives and well-being.

Although empirical studies of ADHD exist in the literature, the lack of research specifically examining the experiences of Black women with undiagnosed ADHD has resulted in significant gaps in understanding how this population experiences and makes meaning of their symptoms prior to receiving a diagnosis. While studies have documented the general impact of late-diagnosed ADHD in adults (Henry & Jones, 2011; Holthe & Langvik, 2017; Horton-Salway & Davies, 2018) and the unique mental health challenges faced by Black women (Nelson et al., 2020; Thorpe et al., 2022; Watson-Singleton et al., 2019), there remains limited exploration of how these experiences intersect and shape the lives of Black women living with undiagnosed ADHD. Thus, understanding the effects of undiagnosed ADHD in Black women requires careful consideration of both individual factors and sociocultural influences. For example, hormonal changes that can significantly impact ADHD symptom presentation in women (Antoniou et al., 2021) intersect with cultural expectations and societal pressures to create unique challenges for Black women. These challenges may be further complicated by the internalized cultural stigma surrounding mental health within the Black community and the limited representation of Black women in ADHD research and treatment development (Waite & Ramsay, 2010).

This complex interplay of factors highlights the need for research that specifically explores how living with undiagnosed ADHD shapes the experiences of Black women across the lifespan. A thorough understanding of the experiences of Black women with undiagnosed ADHD is critical for developing more effective, culturally sensitive approaches to the identification, diagnosis, and treatment of ADHD among this population, while also identifying the broader systemic barriers that contribute to delayed diagnosis and care.

Statement of the Problem

Counseling research has yet to empirically examine the unique experiences of Black women with ADHD who did not receive a diagnosis until adulthood. While ADHD research has evolved beyond its initial focus on children, adolescents, and emerging adults (Young et al., 2020), existing theoretical frameworks and diagnostic criteria may fail to capture the unique experiences of Black women living with undiagnosed ADHD (Waite & Ramsay, 2010). This gap is particularly concerning as Black women are more likely to remain undiagnosed until adulthood compared to other groups (Waite, 2007).

The incidence of delayed diagnoses of ADHD among Black women may be influenced by several factors, including the historical exclusion of Black women from ADHD research and the failure to consider how race, gender, and mental health intersect to shape their experiences. Importantly, ADHD can present differently in women, often manifesting as inattentive symptoms such as disorganization, struggle to manage time, and forgetfulness rather than the hyperactive symptoms more commonly recognized in diagnostic settings (Holthe & Langvik; Quinn, 2005). For Black women specifically, these inattentive symptoms may be misinterpreted through the lens of racial stereotypes or overlooked due to controlling images such as the “Angry Black Woman” (Lewis et al., 2016). Additionally, behaviors stemming from ADHD-related challenges may be misunderstood as intentional acts of defiant behavior (Baglivio et al., 2016), particularly given that Black girls and women are more likely to receive disciplinary actions and be punished more severely for the same behaviors compared to their White counterparts (Epstein et al., 2017; Gibson et al., 2019). Furthermore, while hormonal changes during puberty, menstruation, and menopause can impact ADHD symptom presentation and severity in women (Antoniou et al., 2021; Quinn & Madhoo, 2014), Black women’s experiences of these symptoms may be dismissed or overlooked due to the internalization and expression of the Strong Black Woman schema (Watson-Singleton et al., 2019).

Beyond symptom presentation and recognition, Black women encounter additional systemic barriers to receiving an early ADHD diagnosis. Specifically, these barriers include limited access to culturally competent mental health providers (Lekas et al., 2020; Nicolaidis et al., 2010), financial constraints, and deep-rooted mistrust in healthcare systems stemming from historical and ongoing discrimination (Jones et al., 2014; Martinez-Hume et al., 2016). Despite recognizing mental health concerns, Black women often delay seeking professional help until they have exhausted other coping strategies (Smith et al., 2023), a pattern influenced by cultural stigma and fear of perpetuating negative stereotypes (Alvidrez et al., 2008). Moreover, mental health providers may lack the cultural competence and understanding needed to recognize ADHD symptoms in Black women, which can result in symptoms being misattributed to other conditions (Gara et al., 2019) or overlooked entirely (Ashley, 2014). This lack of understanding often leads to perpetuating racial and gender microaggressions within therapeutic environments (DeBlaere et al., 2023).

The impact of undiagnosed ADHD among Black women manifests across different life domains. Specifically, research indicates that untreated ADHD can lead to substantial challenges in academic achievement, career development (Attoe & Climie, 2023), and interpersonal relationships (Holthe & Langvik, 2017). For Black women, these functional impairments are compounded by gendered racism and cultural expectations in educational and professional settings (Lewis et al., 2016), where ADHD-related challenges may reinforce negative stereotypes and lead to increased criticism (Holder et al., 2015); Womack et al., 2023). Current counseling research, however, provides limited insight into how Black women navigate these intersecting challenges before receiving their ADHD diagnosis. Without empirical investigations in this area, the unique narratives of Black women living with undiagnosed ADHD remain unexplored.

Purpose of the Study and Research Question

Despite growing awareness of ADHD in women, Black women remain significantly underrepresented in both research and clinical understanding of the disorder (Waite & Ramsay, 2010). The intersection of race, gender, and mental health creates unique challenges for Black women seeking ADHD support, particularly given that ADHD diagnostic criteria were developed based on studies that consisted of predominantly male participants (Arnold, 1996; Quinn & Madhoo, 2014). These challenges are compounded by systemic barriers, cultural stigma, and the lack of culturally sensitive diagnostic tools that consider the distinct lived experiences of Black women (Waite & Ivey, 2009).

While research has begun to explore ADHD in adult women (Attoe & Climie, 2023; Henry & Jones, 2011; Holthe & Langvik, 2017), there remains a critical gap in understanding how Black women experience and make meaning of living with undiagnosed ADHD until adulthood. Despite repeated calls from scholars for more attention to and inquiry into diverse cultural and racial populations in ADHD research (Abdelnour et al., 2022; Bussing et al., 2012; Waite & Ivey, 2009), there is a dearth of published literature that specifically addresses the experiences of Black women who remained undiagnosed with ADHD until adulthood. Therefore, the purpose of this qualitative study is to explore the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. By centering the voices of Black women and exploring their experiences through an intersectional lens, this research aims to contribute to more culturally responsive approaches to ADHD assessment, diagnosis, and treatment. To this end, the research question guiding this study is: What are the lived experiences of Black women who remained undiagnosed with ADHD until adulthood?

Significance of the Study

This study aims to understand the lived experiences of Black women who remained undiagnosed with ADHD until adulthood, and, subsequently, has significant implications for counselor education, clinical practice, and future research. Although researchers have highlighted the general impacts of ADHD on adults, the specific experiences of Black women remain largely unexplored (Waite & Ramsay, 2010). The findings from this study will contribute to a more nuanced understanding of how race, gender, and mental health intersect to shape the experiences of Black women living with undiagnosed ADHD and its lasting impacts on their lives.

The proposed study is a response to several critical needs within the existing literature. First, it is a response to repeated calls from scholars for more empirical exploration of ADHD in diverse cultural and racial populations (Abdelnour et al., 2022; Bussing et al., 2012; Waite & Ivey, 2009). Secondly, it examines the impact of living with undiagnosed ADHD on Black women's educational, professional, and personal development, areas in which Black women already face systemic barriers (Lewis et al., 2016). Thirdly, the proposed research study aims to understand how cultural factors, such as the Strong Black Woman schema (Woods-Giscombe, 2010) and mental health stigma in Black communities (Alvidrez et al., 2008), may contribute to delayed ADHD diagnosis among Black women.

The potential implications of this research study extend into multiple areas. For example, the findings of the proposed study may provide insights that could enhance the capacity of mental health clinicians to recognize and assess ADHD symptoms in Black women earlier, potentially preventing years of unnecessary hardship. Specifically, healthcare providers may use the insights found in this study to create more effective screening processes that include nuanced ways in which ADHD may present in Black women. Additionally, the findings of this study may also offer a foundation for transforming how counseling programs prepare and train future counselors to work with Black women. By revealing distinct intersectional challenges, coupled with differences of ADHD presentation among this population, this study can inform more culturally responsive training curriculum in counselor education.

In addition to implications within clinical practice and counselor training, the findings from this study may also support policy changes within the counseling profession needed to address systemic barriers that prevent early ADHD diagnosis among Black women. Specifically, the findings of this study may inform advocacy efforts such as developing more inclusive diagnostic criteria for ADHD, increasing access to culturally competent providers, and calling for better insurance coverage for ADHD assessments. Furthermore, this study may contribute to the development of more effective outreach and education programs. Given the documented lack of mental health literacy among Black women (Loeb et al., 2023) and the limited awareness of ADHD in the Black community (McLeod et al., 2007), understanding the rich narratives of Black women with undiagnosed ADHD until adulthood could inform community-based interventions and educational programs. These initiatives could help address the stigma around mental health concerns within Black communities while simultaneously increasing awareness of ADHD symptoms and available resources. Additionally, the findings may guide the development of support services that specifically address the challenges Black women face while living with undiagnosed ADHD.

In sum, this study fills a crucial gap in both research and practice by centering the voices and experiences of Black women who lived with undiagnosed ADHD until adulthood. Their narratives can provide valuable insights into the real-world impacts of receiving a delayed diagnosis and the systemic changes that are needed to ensure earlier identification and intervention of ADHD. As rates of adult ADHD diagnoses continue to rise (Kosheleff et al., 2023), understanding these experiences among marginalized populations becomes increasingly important for developing more equitable and effective mental health services.

Brief Overview of the Study

This qualitative study employs Interpretive Phenomenological Analysis (IPA) to explore the lived experiences of Black women with ADHD who remained until adulthood. The effects of undiagnosed ADHD on Black women represent a critical yet understudied phenomenon as this population often faces unique challenges due to the compounding effects of racism, sexism, and mental health stigma.

Drawing on an integrated theoretical framework of Intersectionality theory (Crenshaw, 1991) and Black Feminist Thought (BFT) (Collins, 2009), this study acknowledges that Black women’s experiences with undiagnosed ADHD cannot be understood by examining race and or gender separately. Rather, their experiences are shaped by the simultaneous interaction of multiple marginalized identities within societal structures that often overlook their specific needs. Thus, the combined theoretical foundation of Intersectionality theory and BFT guides the study’s focus on understanding how systemic inequities and cultural factors contribute to a delayed diagnosis of ADHD in Black women, while also exploring the occupational, interpersonal, and psychological impacts of living with undiagnosed ADHD.

Using Interpretive Phenomenological Analysis (IPA), I will recruit 10-12 Black, cisgender women aged 25 years or older who were diagnosed with ADHD at the age of 18 or later. Additionally, the participants will confirm they have been raised in the United States from at least the age of five to ensure that they are reflecting upon their experiences of living with undiagnosed ADHD within the U.S. cultural context, particularly during their developmental years. Through in-depth semi-structured interviews, participants will share their experiences of living with undiagnosed ADHD symptoms, including how they made sense of their symptoms prior to receiving a diagnosis and navigated various life domains without appropriate support or understanding.

The IPA methodological approach allows for a nuanced exploration of how Black women interpret and make meaning of their experiences, while acknowledging the complex interplay between their intersecting identities. By centering the voices and perspectives of Black women in the research process, this study aims to contribute to a deeper understanding of how undiagnosed ADHD distinctly impacts this population. The findings may inform the development of more culturally responsive mental health practices and intervention strategies that better address the specific needs of Black women with ADHD, ultimately working towards reducing disparities in ADHD diagnosis and treatment.

Definition of Terms

To provide clarity and context for this study, the following constructs and terms are defined. These definitions aid in the understanding of how each concept is applied within the proposed research study.

Attention- Deficit/ Hyperactivity Disorder (ADHD)

A neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity that interfere with functioning or development across multiple domains. While symptoms typically emerge in childhood, diagnosis can happen at any time (APA, 2013).

Barriers to Mental Health Care

Obstacles that prevent or delay individuals from accessing mental health services. For Black women, these barriers can include cultural stigma, lack of culturally competent providers, mistrust of healthcare systems, financial constraints, and internalized pressures related to the Strong Black Woman (SBW) schema.

Gendered Racism

The simultaneous experience of both racism and sexism, which creates unique forms of discrimination that specifically target Black women because of their intersecting identities (Essed, 1991).

Help-Seeking Behaviors

Actions involved in pursuing support for mental health concerns, including seeking professional treatment, accessing resources, or asking for assistance from others.

Intersectionality Theory

A theoretical framework that examines how multiple social identities such as race, gender, and mental health intersect and create unique experiences of oppression and privilege (Crenshaw, 1991). In mental health contexts, Intersectionality helps clinicians understand how overlapping identities influence diagnosis, treatment, and overall well-being.

Late/Adult ADHD Diagnosis

The identification and formal diagnosis of ADHD by a healthcare professional while the client is an adult (age 18 or older).

Strong Black Woman Schema (SBW)

A culturally embedded belief system that promotes self-reliance, emotional strength, and caregiving among Black women while discouraging vulnerability or help-seeking. (Woods-

Giscombé, 2010). Although it is often viewed as a source of resilience, this schema can prevent Black women from acknowledging mental health challenges or seeking necessary support.

Undiagnosed ADHD

The presence of significant ADHD symptoms that impact daily functioning but have not been formally diagnosed by a healthcare professional. These symptoms cause significant functional impairment and can result in various challenges in academic, occupational, interpersonal, and psychological domains (Quinn & Madhoo, 2014).

Chapter Summary

This chapter has introduced the unique challenges Black women face when living with undiagnosed ADHD and highlighted the critical need to understand their experiences through an integrated lens of Intersectionality and Black Feminist Thought. The Intersection of race, gender, and mental health creates distinct barriers that often result in Black women receiving ADHD diagnosis much later in life, if at all. This delayed recognition and diagnosis can significantly impact various aspects of Black women's lives, including academic achievement, career development, interpersonal relationships, and psychological well-being. The next chapter, Chapter Two, will provide a comprehensive literature review examining how controlling images, the Strong Black Woman schema, and systemic barriers influence Black women's experiences with mental health services. Chapter Two will also explore current research on gender differences in ADHD presentation and the specific challenges Black women face in receiving an earlier diagnosis. Chapter Three will then detail the methodological approach of the proposed study more thoroughly by outlining IPA methodology, research procedures, participant recruitment strategies, data collection methods, and data analysis process.

CHAPTER 2

REVIEW OF THE LITERATURE

Attention Deficit Hyperactivity Disorder (ADHD) is a complex neurodevelopmental condition that can significantly impact individuals across the lifespan and across different domains of daily life. Although there has been substantial research dedicated to the negative effects of ADHD on adults, the specific experiences of Black women who remain undiagnosed until adulthood have been largely unexplored. The aim of this chapter is to examine how undiagnosed ADHD uniquely affects Black women by providing a thorough review of the systemic and cultural factors contributing to their delayed diagnosis and the subsequent negative impacts on their lives. This chapter begins with an overview of the theoretical frameworks that guide this study, providing a lens through which Black women and their engagement with mental health services can be understood. This chapter then dissects the help-seeking behaviors of Black women related to mental health, highlighting the external and internal barriers Black women face that prevent them from receiving adequate mental health treatment. Following this, the chapter then shifts to the exploration of the distinct challenges associated with the diagnosis of ADHD in Black women, specifically discussing the compounding nature of lack of awareness, diagnostic biases, and the potential negative consequences of these challenges. This chapter critically reviews the detrimental effects of undiagnosed ADHD on Black women’s educational attainment, career development, interpersonal relationships, and psychological wellbeing. This literature review aims to draw attention to the importance of addressing this overlooked phenomenon and its significant impact on Black women’s quality of life.

Intersectionality Theory

Intersectionality, a term coined by Kimberly Crenshaw (1991), emphasizes that individuals hold multiple identities, and these identities interact and shape their individual experiences. Intersectionality states that individual identities, including race, gender, socio-economic status, and disability, also intersect with social structures of marginalization and oppression, such as racism, sexism, and classism, creating a nuanced experience (Crenshaw, 1991). Crenshaw (1998) highlighted how Black women are at risk of racism and sexism and how this overlap is often overlooked. During the early feminist rights movement, several initiatives focused on the needs of middle-class White women, excluding the needs of Black women. During the civil rights movement, many of the influential leaders were Black men, which also served to exclude Black women.

Although Crenshaw aided in its recognition, the concept of Intersectionality preexisted long before her work. One of the earliest recognitions of these intersected identities comes from Sojourner Truth's speech "Ain't I a Woman" delivered at the Ohio Women's Rights Convention in 1851:

> That man over there says that women need to be helped into carriages and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man – when I could get it – and bear the lash as well! And ain't I a woman?" (Truth, 1851)

Truth (1851) highlighted the experience of being discriminated against as a woman, but also specifically because of her identity as a Black woman. These overlapping identities put Black women at a unique crossroads with experiences that differ from both those of White women and those of Black men.

To further expand upon the construct of Intersectionality, the librarian's dilemma has been utilized (Purdie-Vaughns & Eibach, 2008). Specifically, readers are asked to imagine a librarian who receives only one copy of a book detailing Black women's history. The librarian is now left to choose which section she will place the book, in the women's history section or the Black history section. If the book is placed in the women's history section, a large group of people may never read the book, and vice versa. Either way, the history of Black women will be missed by a substantial portion of society, depending on how the book is categorized. Thus, the scenario of the librarian's dilemma highlights the unique experience of individuals with overlapping marginalized identities that differ from those with only one marginalized identity. By acknowledging the complexities brought on by the overlapping identities, the experiences of Black women cannot be fully captured through a lens of race or gender alone. Recognizing the historical and theoretical foundations of Intersectionality is essential in understanding its larger implications, especially when it comes to mental health in Black women.

Defining Intersectionality Theory

The construct of Intersectionality has been applied as a theory, yet critics have debated whether it is a theory that should solely focus on multiple marginalization or a theory of multiple identities. Viewing Intersectionality as a theory of multiple marginalizations acknowledges the experiences and challenges of overlapping social identities and how this overlap influences the unique experiences of oppression and privilege (Blackie et al., 2019). However, some critics argue that by viewing Intersectionality as a theory of multiple marginalizations, researchers run the risk of conducting “damage-centered research” that only seeks to focus on the pain and hurt of vulnerable communities, portraying them as wounded, broken, and defeated (Tuck, 2009, p. 413). Viewing Intersectionality as a theory of multiple identities (including both marginalized and dominant) allows for a more generalized lens that examines how different social identities intersect and shape an individual’s experience. This perspective suggests that a person is not defined just by their marginalized identities and includes a broader range of identities, whether dominant or marginal. Critics of this lens assert that it risks recentering dominant groups, such as White women, by taking the focus away from addressing marginalization and structural inequalities (Sibbett, 2020).

Intersectionality in the Mental Health Field

In the mental health field, Intersectionality theory has been used to identify culturally relevant factors and compounding multiple identities that impact different psychological phenomena. Intersectionality theory examines mental health concerns and diagnoses in an individual’s own context, rather than based on the context and cultural norms of those with only one marginalized identity, such as White women or Black men. Instead, an Intersectionality perspective posits that Black women face a unique set of challenges, stereotypes, and barriers that must be considered when exploring their experiences and mental health (Mays et al., 2007; Sternthal et al., 2011). In fact, Green et al. (2017) asserted that incorporating Intersectionality should not be for the simple act of identifying what populations are more at risk but to critically examine how existing systems of power and oppression determine health-related outcomes. In sum, Intersectionality provides a framework that analyzes how various forms of oppression, including sexism, racism, classism, ageism, and homophobia, intersect to produce complex patterns of marginalization, oppression, and disadvantage (Dill & Kohlman, 2012).

Given the importance of Intersectionality, it is not surprising that professional standards and organizations have highlighted the need for the construct to be a primary foundation for effective multicultural research, practice, and treatment within counseling and psychology fields (Clauss-Ehlers et al., 2019). For example, the American Counseling Association (ACA) encourages counselor educators to incorporate topics related to multiculturalism and diversity into all courses and workshops to prepare professional counselors to address the complexities of clients' intersecting identities (ACA, 2014, Standard F.7.c). Additionally, ACA and the Association for Multicultural Counseling and Development (AMCD) have endorsed the Multicultural and Social Justice Counseling Competencies (MSJCC; Ratts et al., 2016), which have expanded the framework for multicultural training by emphasizing social justice, intersectionality, advocacy, and acknowledging marginalized and privileged identities (Gonzalez-Voller et al., 2020). Thus, it is crucial for the counseling profession to integrate Intersectionality as a central component in both education and practice to ensure that counselors are equipped to understand and address the diverse and intersecting identities of their clients.

In addition to training standards, an Intersectionality framework has been shown to be effective in many studies related to mental health. For instance, a study conducted by Adames et al. (2018) found that incorporating an Intersectionality lens when working with Afro-Latinx queer immigrant's experiences in therapy allowed for the consideration of multiple marginalized identities, the impact of systemic oppression, and the client's personal experiences simultaneously. Intersectionality has also been used to explore Black women's unique view of body image concerns, detailing how beauty standards are viewed differently from other racial groups and white-centric beauty standards and norms due to historical uses of the Black woman’s body for physical labor and sexual exploitation (Parker et al., 2022). Moreover, Intersectionality was also utilized in a study assessing HIV stigma and its adverse psychological and behavioral impact, considering the influence of different marginalized identities, including social status, privilege, and sexual orientation (Sun & Farber, 2020).

The aforementioned studies highlight the importance and effectiveness of adopting an Intersectionality perspective in mental health research, demonstrating how this framework can better address the unique experiences and needs of individuals with overlapping marginalized identities (Bryant-Davis, 2019; Goode et al., 2022; Watson-Singleton et al., 2019). Indeed, utilizing an Intersectionality lens can facilitate the development of cultural adaptations to evidence-based interventions, leading to more effective outcomes and increased positive results (Griner & Smith, 2006; Hall et al., 2016). Considering the impact of multiple overlapping identities is necessary to improve outcomes of marginalized populations that may otherwise be overlooked.

The Evolution of Intersectionality Theory

While the concept of Intersectionality is rooted in the experiences of Black women from within the Black feminist movement, there has been discord in the literature regarding whose intersection of identities should be considered, such as Black women only, all Black people, all people with marginalized identities, or all people with multiple identities. Intersectionality theory has evolved to apply to multiple historically oppressed populations with an inclusive aim to highlight the experiences of all marginalized groups, including Black, Indigenous People of Color (BIPOC), and gender and sexual minorities (Bowleg, 2012; Robinson, 2018). Some scholars have argued that Intersectionality as a concept has drastically shifted from its original focus on the “subject position and social location of Black women and the vulnerabilities they face at this intersection” (Cole, 2020, p. 1037) to a framework utilized to explore multiple identities, which, at times, may not address and challenge systems of inequality and oppression, a key component of Intersectionality theory (Dill & Kohlman, 2012). This broader application risks displacing Black women’s experiences, causing them to “disappear” (Alexander-Floyd, 2012, p. 15) in gender-related studies. Cole (2020) and Lewis (2013) expressed a similar argument, asserting that a broader definition of Intersectionality may continue to overlook Black women's unique experiences and challenges. On the other side of the debate, some scholars propose that Intersectionality should be expansive and used to explore a wider range of identities and perspectives, including whiteness and masculinity (Carbado, 2013; Carbin & Edenheim, 2013).

The ongoing debate and lack of a clear definition highlight the need for careful consideration of how Intersectionality is defined and applied when used in research and studies exploring the impacts of multiple salient identities, specifically Black women with undiagnosed ADHD. For this study, the use of Intersectionality theory will maintain Crenshaw’s original focus on the compounding effects of multiple marginalized identities, highlighting the need to acknowledge and critique the intersection of identities in relation to structural systems. Intersectionality will be used to examine how race, gender, and neurodivergence intersect to create unique barriers and experiences for Black with ADHD, centering their voices to understand how these overlapping identities influence their journey to diagnosis. By focusing on the compounding effects of multiple marginalized identities, this study aims to capture the nuances of living with undiagnosed ADHD as a Black woman and provide a comprehensive understanding of the structural inequalities that contribute to delayed diagnosis and treatment.

This focus allows for a deeper exploration of how overlapping marginalized identities interact to impact Black women’s access to ADHD assessment, recognition of symptoms and overall mental health and well-being. However, due to the lack of clarity regarding what populations and identities sit at the intersection of Intersectionality theory, and considering the specific focus of this study, an additional theory is needed to fully and unquestionably center and explore the experiences of Black women, namely, Black Feminist Thought.

Black Feminist Thought

Patricia Collins' (2002) seminal work describing Black Feminist Thought (BFT) builds upon the concept of Intersectionality. At its core, BFT recognizes that gender and race cannot be explored in isolation but must be considered through the lens of how these two identities intersect simultaneously. Thus, BFT holds that the intersection of being Black and a woman provides a unique perspective and focuses specifically on Black women's experiences. Collins argued that centering the experiences of Black women is important to create equitable resources and outlined six features of BFT: (1) Being a Black Woman living in the United States exposes Black women to a common set of experiences due to the structures and societal expectations, (2) The common set of experiences can generate a standpoint that is understood by the collective, which can lead to activism and resistance to oppressive practices, (3) Although the experiences may be common, there is diversity and complexity within those experiences factors, including internal factors, economic and social class, sexual orientation, and family dynamics, (4), Black women intellectuals are called to understand and explore the lived experiences of Black women, which includes asking the right questions and merging academic pursuits with activism and self-definition, (5) As the social climate changes, Black women intellectuals must adapt how they generate knowledge and challenge oppressive practices, and (6) the empowerment of not just Black women, but all marginalized and oppressed groups.

Recently, there has been increased recognition of the importance of centering Black women’s experiences in research, education, mental health, and healthcare (Brantley, 2023; De Sousa & Varcoe, 2021; Jones & Harris, 2019; Oliphant et al., 2022). For example, BFT has been used in research exploring the distinct help-seeking behaviors for depression among Black women (Nelson et al., 2020). By incorporating BFT, Nelson et al. (2020) were able to emphasize how the lasting impacts of slavery influence Black women’s perception of strength, masking pain, and mental health. In another study, Allen et al. (2023) applied BFT to examine Black women's unique challenges and experiences in predominately White institutions. Their research revealed that understanding the microaggressions and systemic barriers that Black women face is necessary for developing specific and tailored initiatives in higher education to promote retention and support. Wilfred and Lundgren (2021) also applied BFT when developing the Double Consciousness Body Image scale, a body assessment tool designed for Black women. The scale ensures cultural sensitivity and relevance by considering cultural body type pressures and addressing body image norms set by White-centric standards.

Using the BFT framework, these studies emphasize the need to empower Black women by acknowledging their unique experiences, challenges, and needs. Understanding the historical context of systemic oppression and mistreatment is essential when addressing the deeply rooted issues that affect Black women today, including mental health. By incorporating BFT into research and practice, it becomes possible to develop more effective and culturally sensitive resources and treatment approaches.

An Integrated Theoretical Approach

Black women face numerous challenges related to racism and oppression in multiple contexts, including work, academia, social interactions, and healthcare (Lewis et al., 2016), the same areas that are often impacted by ADHD (Kosheleff et al., 2023). Although research related to ADHD in women has increased due to the growing concern of the disorder on functional impairment (Kosheleff et al., 2023), there is a lack of research that is solely centered and focused on the experience of ADHD among Black women (Waite, 2009). Given this lack of focus and attention, an integrated BFT and Intersectionality lens offers an opportunity to acknowledge the unique sociocultural perspective generated from the distinct experiences of being Black, a woman, and having undiagnosed ADHD in the United States (Collins, 1989; Collins, 2002; Crenshaw, 1989). By utilizing both Intersectionality and BFT, counselors and scholars can gain a better understanding of how race, gender, and other social identities intersect to shape the experiences of Black women who remained undiagnosed with ADHD until adulthood. Rather than viewing each identity separately, Black women often see their identities as intertwined, impacting multiple areas of their lives and contributing to how they view themselves (Settles, 2006), thus supporting the use of an integrated BFT and Intersectionality approach. This integrated framework allows for a more thorough exploration of how systemic racism, sexism, and other forms of oppression and discrimination impact the diagnosis, treatment, and mental health of Black women.

In addition, this integrated theoretical orientation allows for exploration of undiagnosed ADHD in Black women as a unique phenomenon shaped by distinct cultural, racial, and gender experiences, rather than simply comparing it to the experiences of White women or Black men (Lewis & Williams, 2023). Indeed, a Black woman with a mental health concern, like ADHD, would have three marginalized identities: being Black, being a woman, and having a mental health condition, placing Black women in triple jeopardy (Chapagain, 2020). Thus, by exploring the nuances of undiagnosed ADHD through an integrated lens of BFT and Intersectionality, clinicians and scholars can increase their understanding and gain a more holistic view of how Black women experience ADHD.

Gender, Race, and Mental Health

Gender and race are critical when exploring mental health due to the perceived and actual differences caused by the intersection of these salient identities. Historically, the mental health field and research practices have utilized frameworks and perspectives that often exclude and oppress the unique experiences of minority populations (Eriksen & Kress, 2008). Among these underserved groups, Black women are a prime example of how systemic biases and cultural blindness in mental health research can lead to detrimental gaps in understanding, diagnosis, and treatment. These gaps can be attributed to a variety of external and internal factors, including gendered racism.

Gendered Racism

The intersection of being Black and a woman often leaves Black women vulnerable to experiencing gendered racism, a term coined by Essed (1991). Gendered racism is used to describe a “hybrid phenomenon” (Essed, 1991, p. 31), which shapes the experiences of Black women because of discrimination and oppression based on their converging identities of being Black and a woman (Lewis et al., 2017). Black women face significant health and psychological disparities because of gendered racism. For example, gendered racism has been linked to increased psychological stress and physical health, including obesity (Tipre & Carson, 2022), depression (Burton et al., 2022), anxiety (Jones et al., 2021), and lower self-esteem (King, 2003).

Black women also continue to face systemic racial and sexist stereotypes and practices that affect multiple areas of life, including education (Womack et al., 2023), employment (Holder et al., 2015), healthcare (Barnett et al., 2022), and the criminal justice system (Powell & Phelps, 2021). For example, in a longitudinal study of Black women pursuing higher education, participants shared their experiences navigating racial and gendered stereotypes from their professors (Womack et al., 2023). They reported instances such as being misidentified with another Black female student and having their ideas and contributions ignored over their male colleagues. These experiences led to feelings of imposter syndrome and pressure to work harder (Womack et al., 2023). Likewise, Powell and Phelps (2021) found that Black women often face the dual frustration that comes from wanting to call on law enforcement for protection against neighborhood, family, or partner violence and yet hesitate due to the history of mistreatment and violence from law enforcement because of race, gender, or both.

Gendered racism can show up in blatant ways, such as unequal pay, discriminatory policies, and degrading language, as well as more covert and subtler ways, such as gendered racial stereotypes, microaggressions, and silencing. Microaggressions are often subtle, verbal, or nonverbal insults and behaviors that are more covert signs of racism, making them difficult to identify (Pierce, 1970). Whether intentional or unintentional, microaggressions are brief everyday interactions that demean and belittle people of color (Sue et al., 2007). Specifically, Black women face gendered racial microaggressions related to projected stereotypes (such as the Angry Black Woman), questioning of their authority in professional settings, and assumptions about how they should speak or dress (Lewis et al., 2016). Sue et al. (2007) identified nine categories of racial microaggressive themes, some of which are particularly harmful to Black women. The first significant theme is “Ascription of Intelligence,” which assigns a level of intelligence to a person based on their race. Second is the theme of "Second Class Citizen," where individuals are treated as less than because of their race. These microaggressive categorizations of intelligence and treatment are concerning due to the perpetuated stereotype that Black individuals are deemed to be less intelligent than the dominant race (Zou & Cheryan, 2017). Specifically, Black women are more likely to be seen as intellectually and competently inferior, have their authority questioned in the workplace, and are excluded from workplace activities (Holder et al., 2015; Lewis et al., 2016).

The third microaggression theme that poses a specific risk to Black women is the "Assumption of Criminality," or dangerousness, which assumes that a group or person is automatically dangerous, or deviant based on race (Sue et al., 2007). This assumption significantly impacts Black individuals daily by leading to biased treatment, being watched more closely, and being a target of discriminatory behaviors (Thiem et al., 2019; Williams et al., 2020). For example, Black students have reported being perceived as a threat by White students based on their appearance (Williams et al., 2020).

For Black women, the assumption of criminality starts early and can lead to a host of detrimental consequences. Specifically, compared to White girls, Black girls are more likely to receive more disciplinary actions in school (Epstein et al., 2017), be sentenced more harshly, and be punished more severely for the same offense (Crenshaw et al., 2015; Drew et al., 2022; Moore & Padavic, 2010). Behaviors stemming from actual mental health-related challenges may run the risk of being misunderstood and misinterpreted as intentional acts of defiant behaviors (Baglivio et al., 2016), exacerbating the challenges Black women face from childhood through adulthood.

Consistent with Sue's (2007) microaggression categories, additional research has identified similar categories and assumptions of microaggressions and how they impact minority populations. For instance, Banks and Landau (2021) and Smith et al. (2007) explored the negative consequences of these microaggressions on the overall well-being of marginalized populations. Among Black women at a predominately White Institution, Banks and Landau (2021) found that the students who experienced racial microaggressions noticed a significant decrease in their cognitive ability to perform mental tasks.

Further research has been conducted to account for the distinct interplay between microaggressions, race, and gender. Building on past research (Lewis et al., 2013), Lewis and Neville (2015) developed an assessment scale to account for the intersection of race and gender in the experiences of Black women. This study captured four themes of gendered racial microaggressions experienced by Black women: (a) Assumptions of Beauty and Sexual Objectification (stereotypes about Black women's beauty that lead to objectification and unrealistic beauty standards), (b) Silenced and Marginalized (Black women's voices and experiences are dismissed and undervalued), (c) The Strong Black Woman Stereotype (viewing Black women as perpetually strong and resilient leading to unrealistic expectations and negating their need for support), and (d) Angry Black Woman Stereotype (labeling Black women as angry or aggressive and invalidating their emotions) (Lewis & Neville, 2015). Experiences of gendered racism, whether covert or direct, can have significant psychological impacts on Black women (Moody & Lewis, 2019; Nadal et al., 2014) that may be unique from the experiences of Black men or White women. Consequently, it is imperative to assess the utilization of mental health services among Black women specifically.

Help-Seeking Behaviors Among Black Women

Despite recognizing the negative impact of mental health symptoms, a substantial number of Black women do not seek professional help (González et al., 2010). This gap between awareness and action is evident in several studies. For example, Nelson et al. (2020) interviewed 30 Black women who all believed that seeking support to treat depression was important. However, only 20 of these women reported that they would actually seek treatment for themselves, with 60% reporting that their symptoms must be severe or chronic. Similarly, Smith et al. (2023) found that Black women will turn to professional psychological services only after they have exhausted all other coping strategies, such as exercise, prayer, and informal support. This reluctance to seek formal mental health care is further highlighted in a study by Sosulski and Woodward (2013), which focused on Black women diagnosed with mental health conditions like anxiety, substance use, and mood disorders. They found that 23% of Black women relied on informal support, while 16% of Black women did not seek help in any form at all. Considering these utilization rates, it is important to understand external and internal barriers to seeking mental health services among Black women.

Barriers to Seeking Mental Health Services

Black women face numerous obstacles when seeking both physical and mental healthcare services due to deeply rooted historical and contemporary forms of racism and sexism. Societal expectations, controlling images, and ingrained stereotypes often depict Black women in harmful ways and influence their hesitancy to seek help. This section explores these barriers and their impact on the mental health and help-seeking behaviors of Black women.

Controlling Images

One potential barrier to help-seeking among Black women is the impact of controlling images, or stereotypes and images used to define and control minority groups by perpetuating harmful perceptions based on their race and gender. Patricia Hill Collins (2000) asserted that these controlling images are “designed to make racism, sexism, poverty, and other forms of social injustice appear to be natural, normal, and inevitable parts of everyday life” (p. 69). These images are deeply embedded in societal structures and used to justify discrimination and violence toward marginalized populations (Collins, 2000). Originating from slavery, Black women were often dehumanized and forced into caretaking roles such as “Mammies” or objectified and viewed as hypersexualized “Jezebels.” These images were not only used to justify and blame the sexual abuse and oppression of Black women by falsely portraying their behavior, but they also contribute to a lasting narrative that continues to affect them (Collins, 2000). Other harmful stereotypes, such as the “Angry Black Woman” or the “Sapphire,” portray Black women as aggressive, loud, and overly emotional. These portrayals lead to Black women being discredited, silenced, and isolated in personal, academic, and professional environments (Kilgore et al., 2020).

Constant exposure to these controlling images and stereotypes can negatively influence the help-seeking behaviors of Black women. The stark contrast between the negative narratives of Black women and the more feminine images used to portray White women as gentle, sensitive, and nurturing (Donovan, 2011) reinforces racial stereotypes and marginalizes the experiences of Black women. For example, Goff et al. (2008) found that Black women were viewed as less attractive than White women and as more masculine due to the association of Blackness and maleness, illustrating how these stereotypes intersect with perceptions of femininity. The complex interplay of societal stigmas, stereotypes, and cultural beliefs not only contributes to mental health challenges but also creates barriers to seeking help. Black women may internalize these stereotypes and, instead of being more expressive and direct when they are victims of sexism, racism, or other offenses, will instead suppress their anger (Jerald et al., 2017) to avoid being labeled as the “Angry Black Woman” (Lewis et al., 2016). This suppression can lead to increased stress and maladaptive coping, such as not prioritizing their health and increased substance use (Jerald et al., 2017). Moreover, the simple awareness of these negative stereotypes, even without internalizing them, can lead to depressive symptoms, irregular sleep, anxiety, and stress (Jerald et al., 2017). This heightened awareness can discourage Black women from seeking mental health services, fearing that they may be further stereotyped in clinical settings.

Strong Black Woman Schema

Another barrier to mental health help-seeking among Black women is the Strong Black Woman (SBW) schema. The SBW schema, rooted in slavery, was developed to justify the extreme physical, emotional, and mental burdens placed on Black women contrary to the life of privilege and ease of White women (Harris-Lacewell, 2001). This schema was internalized by Black women as a form of protection against harmful stereotypes and labels such as “Jezebel” and the “Welfare Queen” against Black women (Collins, 2010). As a result, many Black women have adopted the SBW schema as a survival mechanism, which often serves as a double-edged sword (Beauboeuf-Lafontant, 2007; Nicolaidis et al., 2010; Woods-Giscombé, 2010). The SBW schema represents expectations, beliefs, and personality traits that internalize perseverance, self-reliance, and emotional resilience (Woods-Giscombé, 2010). While many Black women view the embodiment of the SBW as empowering and a source of resilience, it has been shown to have harmful effects as well. Research focusing on Black women’s perception of the SBW schema revealed that the internalization of the SBW role led to an increase in anxiety, depression, and associating the acknowledgment of pain with weakness (Nelson et al., 2020). Additionally, Black women who take on the SBW schema perceive that they have less community and emotional support and will attempt to manage their stressors and mental health struggles alone (Watson-Singleton, 2017). Indeed, Black women who adopt this schema often feel pressure to project an image of strength and resilience despite the psychological costs (Watson-Singleton et al., 2019).

Importantly, the SBW schema can have notable effects on the help-seeking behaviors of Black women. Due to fear of being perceived negatively or as weak, Black women may underreport their mental health symptoms or minimize what they are experiencing, reinforcing the tendency to avoid seeking support from helping professionals (Ashley, 2014). In addition, the SBW schema can lead to heightened anxiety and depression while also decreasing the likelihood of seeking psychological help (Watson & Hunter, 2015). Furthermore, Black women have reported feelings of shame and fear of being negatively judged by others if they were to ask for help (Avent Harris et al., 2020), leading to isolation. Thus, the pressure to maintain this SBW image can deter Black women from seeking mental health support because acknowledging that outside help is needed directly contradicts the SBW archetype (Watson-Singleton et al., 2019). These patterns can have damaging effects on Black women’s help-seeking behaviors, as well as their overall well-being.

Mistrust of Helping Professionals

The historical and contemporary mistreatment of Black women in healthcare environments has created a deep-rooted mistrust of helping professionals, which can be a significant barrier to mental health help-seeking. This distrust is rooted in an extended history of racism spanning from the use of enslaved Black women in harmful medical experiments (Washington, 2008) to present-day disparities in maternal mortality rates (Hoyert, 2022). The impact of these disparities and injustices has extended beyond physical health to mental health, where Black women are often hesitant to seek services (Jones et al., 2014). In multiple studies, it was found that mistrust of the healthcare system served as a significant factor in Black women not seeking help for mental health concerns (Burkett, 2017; Jones et al., 2014; Ullman & Lorenz, 2020). For example, in a study by Jones et al. (2014), which included a sample of 29 Black women who received mental health services, participants expressed mistrust towards service providers and treatment methods. Specifically, the barriers reported included a lack of trust and understanding towards White clinicians, with participants feeling that providers of a different race could not fully relate to their experiences. Participants also shared concerns about not being understood by clinicians who were not Black and who may ignore race-related issues in treatment, which led them to feel unheard and unrecognized. Similarly, using a mixed methods approach, Ullman and Lorenz (2020) studied over 800 Black women who had experienced unwanted sexual experiences and found that participants had a deeply rooted mistrust of mental health providers, influenced by cultural barriers and past negative experiences, such as therapists violating confidentiality.

When Black women do seek treatment, many have reported receiving inadequate or culturally insensitive care (Gara et al., 2019). Issues including overlooked diagnoses or often feeling dismissed by helping professionals due to racism have been common experiences among Black women (Nicolaidis et al., 2010). Notably, in a study conducted by Nicolaidis et al. (2010) to explore how Black women perceive care and treatment for depression, participants described past experiences with White mental health providers as inadequate, reporting insufficient explanations, not spending enough time with them, and disrespecting their intelligence. These negative experiences shaped their view of mental health professionals, resulting in participants refusing to partake in treatment to address depression if the counselor was not Black. Additionally, participants were hesitant to disclose information, emphasizing that these concerns were not due to race but racism (Nicolaidis et al., 2010).

Furthermore, socioeconomic factors, such as the type of insurance used, also play a role in the perceived quality of care. Black women with public insurance, as opposed to private insurance, often report feeling rushed in healthcare experiences, connecting their experience to their socioeconomic status (Martinez-Hume et al., 2016; Thompson et al., 2012). These experiences of being undervalued in healthcare settings contribute to further mistrust of helping professionals, with historical and ongoing injustices adding to this mistrust and serving as a barrier to Black women seeking and receiving mental health treatment.

Lack of Multiculturally Competent Providers

For Black women, the lack of culturally competent mental health providers can result in significant barriers to seeking mental health services. In mental health care, cultural competence and cultural humility are crucial for providing effective person-centered treatment that acknowledges and respects the diverse cultural backgrounds of clients (Lekas et al., 2020). Research indicates that clients who perceive their clinician as culturally competent are more likely to lead to positive therapeutic outcomes and increase satisfaction ratings (Constantine, 2002), especially when working with minority populations (Gonzalez et al., 2018). The need for culturally competent providers is emphasized by research showing that the provider's competence level is a greater preference factor in care than providers who share a racial, ethnic, or cultural identity (Cuevas et al., 2016). In other words, Black women prefer a provider with specific skills who can thoroughly answer questions and concerns regardless of the provider's race (Thorpe et al., 2022).

When mental health providers lack cultural competence, it can lead to health disparities, misinterpretation of client behaviors, ineffective treatments, and even misdiagnosis (Ashley, 2014). For instance, Ashley (2014) highlights that clinicians who may not be aware of common stereotypes of Black women may overlook legitimate reasons for a Black woman's anger, fail to address underlying issues that may be causing psychological distress, and therefore provide inadequate treatment. As a result of this disconnect, Black women may doubt healthcare providers' ability to understand their salient identities and their specific experiences (Silas & Seward, 2023), which may contribute to the hesitancy of Black women to seek help for mental health concerns. Ensuring multicultural competence among clinicians is challenging, given that research has shown discrepancies in self-reported levels of cultural competence among therapists when compared to client-observed levels (Cartwright et al., 2008). These discrepancies highlight that therapists may overestimate their ability to effectively engage with culturally diverse clients. This gap in self-awareness and practice can lead to harmful consequences in therapeutic interactions. For example, research has highlighted that Black Indigenous Women of Color (BIWOC) experienced at least one racial and gender microaggression from their therapist and reported higher levels of microaggressions from White therapists compared to therapists of other racial backgrounds (DeBlaere et al., 2023). They also found that both racial and gender microaggressions had a negative impact on a therapist's cultural humility, the working alliance, and positive therapy outcomes (DeBlaere et al., 2023). Therefore, the lack of culturally competent mental health providers not only leads to a lower quality of care for Black women but also creates mistrust and hesitation to seek mental health support when needed.

Clinical Misdiagnosis

Another barrier to Black women seeking mental health services is the risk of clinical misdiagnoses. Historically, the issue of misdiagnosis of minoritized populations across different health-related fields has been prevalent. Research shows that Black individuals are frequently overlooked for mood disorders such as major depressive disorder or post-traumatic stress disorder and over-diagnosed for disorders such as bipolar and schizophrenia (Jegarl et al., 2023). In mental health assessments, contrasting stereotypes about Black and White women can lead to significant differences in diagnoses and treatment plans (Neighbors et al., 2003; Loring & Powell, 1988). For example, Black women showing symptoms of depression may be more likely to receive a diagnosis of a severe mental health condition such as schizophrenia influenced by stereotypes and biases that perceive Black women as more combative and unstable (Metzyl, 2009). On the other hand, White women are more likely to be diagnosed with mood disorders such as anxiety and depression, influenced by perceptions that they are more emotionally sensitive and fragile (Catalao et al., 2022; Metzyl, 2009).

A lack of knowledge related to the diverse presentations of mental health concerns also contributes to these misdiagnoses (Genna & Feske, 2013). Specifically, in their study exploring racial differences in borderline personality disorder (BPD), Genna and Feske (2013) found that Black women with BPD often present with more externalizing symptoms, such as increased lack of control, but fewer suicidal behaviors, a key determinant when assessing for BPD. This difference in presentation can cause clinicians to overlook BPD as a diagnosis in Black women and instead provide medication and treatment for a misdiagnosis of Bipolar I Disorder (Genna & Feske, 2013). Similarly, Black women are typically overlooked for autism due to presenting with symptoms not consistent with the latest *Diagnostic and Statistical Manual of Mental Disorders*

(5th ed.; American Psychiatric Association [APA], 2013), resulting in being diagnosed at an older age (Diemer et al., 2022). These misdiagnoses can stem from the intersection of racial, gender, structural, and cultural biases that distort perceptions and lead to incorrect clinical judgments and decisions.

Another contributing factor to the prevalence of clinical misdiagnosis among Black women is their underrepresentation in research and treatment assessments. Because minorities, including Black participants, are often not included or underrepresented in research studies, assessments and diagnostic criteria may not be sensitive to these populations. For example, research conducted by Capodilupo and Forsyth (2014) and Goode et al. (2020) highlighted the alarming lack of focus on understanding the nuances of eating disorders and body image concerns among Black women. In an extensive literature review and meta-analysis, Capodilupo and Forsyth (2014) emphasized that women of color experience these concerns differently based on factors like race, ethnicity, social class, and age, differences that current research methods frequently overlook. Specifically, Goode et al. (2020) noted that cultural factors and the language used in the self-reported diagnostic criteria for eating disorders may contribute to the underreporting of symptoms among Black women. These analyses emphasized that clinicians often miss eating disorders in Black women because current diagnostic criteria are based on symptoms observed in White women, leading to underdiagnosis or undertreatment. Therefore, the issue of misdiagnosis not only leads to inadequate treatment but also may discourage Black women from seeking help due to the fear of being misunderstood and wrongly labeled.

Cultural Stigma in the Black Community

While healthcare professionals and structural barriers play a crucial role in influencing the help-seeking behaviors of Black women, it also is important to discuss the cultural stigmas that significantly influence help-seeking. Specifically, Black women may hesitate to seek mental health services due to stigma within the Black community. Stigma, as it applies to mental health help-seeking, involves the negative attitudes and beliefs that cause individuals to avoid seeking help due to fear of judgment, discrimination, or being seen as weak or unstable (Ahad et al., 2023; Parcesepe & Cabassa, 2012). Participants in Alvidrez et al.'s (2008) study included 34 individuals who were receiving mental health services or had received services in the past (41% Black women). The researchers explored how stigma affects Black consumer's engagement with seeking mental health services. The findings revealed that participants expressed more concerns about the stigma associated with seeking professional help and potential negative perceptions from the Black community than about having a mental health-related concern in the first place. This stigma can result in Black women underreporting symptoms out of fear of being judged or viewed negatively by members of the Black community (Alvidrez et al., 2008).

The added effects of cultural stigmas can generate cycles of silencing and self-reliance, which can prevent Black women from seeking the mental health services they need. For many Black women, pressures to stay silent rather than seeking help have been passed down through generations (Scott et al., 2023). A study involving 16 Black women between the ages of 18-39 explored how self-silencing continues to impact the mental and physical well-being of Black women today. This study revealed that this self-silencing behavior was inherited from elders and parents, rooted in the harsh realities faced by their ancestors. Additionally, the fear of perpetuating negative stereotypes about Black women or facing judgment from their community reinforces the cycle of self-silencing (Scott et al., 2023). For example, even when a Black woman personally has a positive view of seeking and utilizing mental health services, pressures and influences from family and interpersonal relationships can cause hesitancy in seeking help for mental health concerns (Suggs et al., 2023).

Lack of Access to Resources

Lack of access to mental health resources can present another barrier to Black women seeking and receiving mental health services. Some access challenges include the cost of services, time constraints (Suggs et al., 2023), employment, a shortage of Black mental health providers, and a lack of insurance coverage (Ormond et al., 2019). Financial barriers to seeking mental health-related care disproportionately affect Black Americans due to historically being more likely to live below the poverty level when compared to other racial groups (APA, 2017). Multiple studies have found economic barriers, including lack of insurance, lack of transportation, cost of services, and lack of employment, as significant hindrances to receiving and seeking mental health treatment (Borba et al., 2012; Ormond et al., 2021; Ward et al., 2009). Moreover, unemployment and underemployment can make it difficult for Black women to prioritize mental health care over more immediate needs such as food and housing (Burkett, 2017). Furthermore, the high costs of treatment and services can discourage individuals from exploring needed care, which can increase the impact of negative symptoms over time (Copeland & Snyder, 2011). These financial stressors not only limit access to care but also contribute to increased depressive and anxiety symptoms among Black women (Copeland & Snyder, 2011). For example, in samples comprised mostly of Black women, Whittle et al. (2019) found that food insecurity was positively linked to PTSD symptoms, while Holmes et al. (2021) connected lower income and lack of available resources to PTSD symptoms.

In addition to financial limitations, the lack of treatment providers or access to treatment centers themselves may serve as a barrier to mental health help seeking among Black women.

Specifically, Hines-Martin et al. (2003) highlighted that opportunities for early intervention among Black women were often missed due to the lack of professional resources and support, resulting in long wait times and limited availability, which led to an increase in the severity of mental health symptoms over time. These compounded challenges illustrate how the lack of access to resources serves as yet another barrier to Black women seeking and receiving the mental health treatment they need.

Black Mental Health Providers

One significant barrier to seeking mental health services among Black women is the lack of Black providers, specifically Black women, in the mental health field. Black women often seek quality providers who are Black women themselves (Thorpe et al., 2022). This preference is often due to the perception that Black female therapists will be more attuned to their cultural background and more likely to limit potential discrimination (Philip & Maimon, 2023; Thorpe et al., 2022). However. according to research by the APA (2017), only 2% of psychologists are Black women out of the total 4% who are Black. This shortage is concerning considering the evidence supporting that attending to client preferences, including racial or ethnic matching between therapist and client, can have significant benefits (Cabral & Smith, 2011; Smith & Wermeling, 2007).

While Black women prefer providers with overall cultural competence when seeking mental health services, they also maintain a strong preference to be matched with a therapist who shares a similar racial or ethnic identity when identity preferences were stated (Cabral & Smith, 2011). This preference is not merely due to racial matching but involves the desire to feel comfortable and understood stemming from shared cultural experiences. Black women often feel more at ease being vulnerable with a provider who can relate to their unique experiences and needs (Thorpe et al., 2022).

Studies have shown that the working alliance, defined as the collaborative bond between a therapist and the client, is a significant factor in client success and positive therapeutic outcomes (Burris, 2012; Horvath et al., 2011; Zilcha-Mano et al., 2017). Meeting client preferences for a therapist who shares their racial or ethnic identities can create a strong working alliance by leading to more positive perceptions of the therapist, better engagement, and decreasing the chances of stopping counseling services before treatment goals have been reached (Sidani, 2023; Swift et al., 2018). Increasing the number of Black women mental health providers could lead to increased help-seeking behaviors in Black women, more positive outcomes, and longer treatment retention among Black clients.

Lack of Mental Health Literacy

Another potential barrier to mental health help-seeking among Black women is the lack of mental health literacy. Indeed, researchers have found that Black women often do not seek mental health services due to a lack of information about services, assessment, or treatment (Loeb et al., 2023; Suggs et al., 2023). Jorm et al. (1997) coined the term *mental health literacy* to describe the “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (p. 182). Jorm (2012) asserted that mental health literacy is not merely about knowledge, but it requires an action that positively impacts the person’s mental health, such as seeking available resources or self-care strategies to cope with manageable symptoms. Indeed, Pederson et al. (2022) found that Black adults who were aware of specific mental-related illnesses such as schizophrenia and bipolar disorder were more willing to seek professional mental health services for emotional and personal concerns.

However, a disproportionate lack of mental health literacy was found in a study conducted at a Historically Black College (HBCU), where a significant number of students were unaware of available mental health resources, with 25% of the participants indicating not knowing where to find these resources (Ayyad et al., 2023). Similarly, in a study exploring Black women's personal experiences and decisions to engage in professional counseling, participants expressed being unaware of available resources and the lack of personal connections with individuals who had sought counseling services before (Smith et al., 2023). Participants also discussed ambiguity about the counseling process itself, noting that their only exposure to counseling came from media and movies, which often led to an inaccurate or incomplete understanding of mental health services (Smith et al., 2023). This lack of direct knowledge and exposure highlights the issue of limited mental health literacy, making it challenging for Black women to recognize when and how to seek mental health support and treatment.

Given the many barriers to mental health help-seeking among Black women, it is not surprising that many mental health concerns go undiagnosed or are diagnosed later in life. One mental health concern that may be diagnosed later among Black women is Attention-deficit hyperactivity disorder (ADHD).

ADHD

According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), ADHD is defined as a "persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (APA, 2013, p. 61). The DSM-5 recognizes three subtypes of ADHD: predominately inattentive, predominately hyperactive-impulsive presentation, and combined presentation. To receive a diagnosis of predominately inattentive ADHD in adults, five (or more) inattentive symptoms must persist for at least six months to a degree that is inconsistent with the adult's developmental level and that negatively impacts social and academic/occupational activities. Inattentive symptoms may include failing to pay attention to details, trouble focusing, and often losing important items needed to complete a task. For a diagnosis of predominately hyperactive ADHD in adults, five (or more) hyperactivity symptoms must persist for at least six months to a degree that is inconsistent with the adult's developmental level and that directly negatively impacts social and academic/occupational activities. Hyperactive symptoms may consist of talking excessively and feeling restless. For a combined presentation diagnosis, an adult must meet the criteria for both inattentive ADHD and hyperactivity symptoms (Leahy, 2018).

ADHD is a commonly diagnosed developmental disorder that affects about 4.4% of adults (Kessler, 2006) and 11.4% of children in the United States (Danielson et al., 2024). Symptoms of ADHD typically emerge in early childhood before the age of 12, but symptoms often persist into adulthood (Faraone et al., 2006). ADHD was once believed to be a disorder that only affected children, with the assumption that symptoms would disappear or diminish by adulthood. However, studies have since proven that symptoms of ADHD persist well into adulthood and cause impairments in different areas of an individual's life across the lifespan (Faraone et al., 2006). For instance, past longitudinal research has revealed that children who met the criteria for ADHD appeared to have fewer symptoms by the time they reached the age of 25 (Faraone et al., 2006). However, researchers noted that the apparent decrease in symptomology may be misleading and is better explained by the lack of sensitivity to how ADHD may change in presentation over the lifespan rather than a decrease in the disorder itself (Faraone et al., 2005). For example, hyperactivity among children with ADHD may transition into restlessness as adults, a behavior less likely to be recognized as an ADHD symptom, specifically given the different expectations placed on children versus adults.

Healthcare professionals, including pediatricians, family physicians, psychiatrists, and counselors, can assess and diagnose ADHD (Wolraich et al., 2019); however, teachers are typically the first to notice symptoms in children because of their ability to observe ADHD symptoms such as hyperactivity, distractibility, and social interactions in the structured classroom environment (Elder, 2010; Jiang et al., 2019). In adults, close family members, partners, friends, or the individual themself may notice difficulties in different environments and with certain responsibilities, leading them to seek a professional assessment for ADHD (Eakin et al., 2004; Wasserstein, 2005).

ADHD is assessed using a variety of methods, including attention tests, comprehensive and evidence-based assessments (Eng et al., 2023), self-report surveys (Kessler et al., 2005), and can involve multiple informants such as teachers and parents (Izzo et al., 2018). In regard to treatment, a combination of approaches are used to address ADHD in adults, including behavioral interventions, mindfulness strategies, neurofeedback, and pharmacological stimulants (Núñez-Jaramillo et al., 2021). Psychoeducation has also been reported to play a significant role in positive treatment outcomes in adults with ADHD (Weiss & Hechtman, 2006).

ADHD can affect any individual, yet there has been evidence of notable differences in the prevalence of ADHD diagnosis across genders, particularly in childhood (Groenewald et al., 2009l; Hinshaw et al., 2022), with boys being diagnosed approximately two to three times more often than girls (Bruchmuller et al., 2011). This difference in prevalence rates is largely due to how symptoms of ADHD present in girls and potential biases that make it difficult to recognize these symptoms (Groenewald et al., 2009; Sciutto et al., 2004). For instance, Sciutto et al. (2004)

found that teachers were more likely to refer boys who presented with ADHD symptoms for assessment than girls, especially if hyperactivity symptoms were present. Despite the differences in diagnostic rates, it does not necessarily mean that there is a lower prevalence rate of ADHD in girls. In fact, a longitudinal study by Moffitt et al. (2015) supported this notion, showing that although there were higher prevalence rates of ADHD in males during childhood, prevalence was nearly equal between men and women as adults. These findings suggest that ADHD may go undiagnosed in girls during childhood and be identified in women after they reach adulthood. Therefore, the symptoms and patterns of ADHD may be overlooked in girls, which highlights the importance of understanding how ADHD presents in women across the lifespan.

ADHD Among Women

Research has shown that ADHD symptoms present differently in women than they do in men, which often contributes to women being diagnosed much later in life (Young et al., 2020). The presentation of ADHD in women tends to show up in more covert and internalized ways than in men, which decreases the likelihood that women are referred for an assessment, resulting in their needs going unmet (Zambo, 2008). Rather than experiencing the hyperactive symptoms of ADHD, women may experience inattentive symptoms such as disorganization, struggling to manage time, and forgetfulness (Holthe & Langvik, 2017). Understanding the factors that contribute to missed or delayed diagnosis of ADHD in women is crucial, considering the impact that these symptoms can have on their mental health and overall quality of life.

Lack of Awareness of ADHD Gender differences

One significant factor that contributes to a missed or delayed diagnosis of ADHD in women is the lack of awareness among clinicians and society of the diverse ways in which ADHD can present (Taylor & Keltner, 2009). Women with ADHD are more likely to experience inattentive symptoms, such as disorganization, procrastination, and difficulties with time management, rather than the hyperactive symptoms more commonly seen in men (Quinn, 2005). Inattentive symptoms can be easily overlooked or dismissed, specifically in clinical settings that are not fully aware of the unique nuances of ADHD in adult women (Waite, 2007). In addition, research has shown that although there is not one exact cause of ADHD, differences in hormonal changes may lead to observable ADHD symptoms manifesting during puberty in girls (Eng et al., 2023), which is much later than when these observable behaviors typically appear in boys (Biederman et al., 2004). Furthermore, hormonal changes during menopause or a woman's monthly menstrual cycle can lead to an increase in ADHD impairment due to these fluctuating levels (Antoniou et al., 2021). For example, the sudden decrease in estrogen has been linked to heightened ADHD symptoms, including increased impulsivity, inattention, and emotion dysregulation (Quinn & Madhoo, 2014). Failure to recognize the more subtle inattentive symptoms of ADHD and distinct hormonal influences can perpetuate the cycle of missed or delayed ADHD diagnosis in women.

In addition to the presentation of ADHD through inattentive symptoms, gender roles and societal expectations of women can also contribute to a missed or delayed diagnosis of ADHD in adult women. Gender norms influence not only how ADHD symptoms manifest in women but also how they are perceived and evaluated by healthcare professionals, educators, and the women themselves (Attoe & Climie, 2023). For example, women are expected to be organized, nurturing, and responsible, specifically when it comes to managing a household or caregiving. However, ADHD symptoms such as forgetfulness, disorganization, and impulsivity directly contradict these expectations. A woman with ADHD may struggle to maintain routines or meet household demands, leading to feelings of inadequacy or guilt (Hayashi et al., 2019). These contradictions may result in women being judged more harshly for their symptoms, or they may internalize societal expectations, working harder to mask and compensate for their symptoms (Quinn, 2005). This can lead to significant emotional distress and exhaustion as women strive to conform to these societal roles while managing untreated ADHD (Hinshaw et al., 2021).

While knowledge and the conceptualization of ADHD have continued to evolve over time with continued research, unfortunately, assessment criteria for the disorder have not (Matte et al., 2012). Diagnostic criteria for ADHD were developed based on studies that included predominately male participants and focused largely on the behavioral manifestations of ADHD (Arnold, 1996). Despite the growing awareness of ADHD in women, the continued use of potentially outdated criteria, which fail to account for gender differences, can contribute to the underdiagnosis and misdiagnosis of women with ADHD (Rucklidge, 2010). Therefore, this gap between evolving research and stagnant diagnostic criteria highlights the need for more gender-sensitive diagnostic tools that reflect the nuanced ways ADHD manifests in women.

Overlapping Symptomology

ADHD symptoms may be overlooked or misdiagnosed as other conditions among women due to the likelihood of overlapping symptomology. The overlapping nature of psychiatric symptoms makes it harder to properly assess ADHD and may lead to a misdiagnosis (Waite, 2007). For instance, symptoms like inattentiveness, restlessness, or emotional dysregulation are commonly seen in both ADHD and other conditions, such as anxiety and depression, making it difficult for clinicians to distinguish between them (Attoe & Climie, 2023; Reimherr et al., 2017). Research has revealed that by the time adults with ADHD seek treatment for their symptoms, ADHD is usually not their primary reason for seeking mental health services (Faraone et al, 2004). Faraone et al. (2004) reported the top five reasons for a psychiatric referral amongst adults with undiagnosed ADHD, which included depression, anxiety, panic attacks, temper control, and generalized anxiety disorder. However, upon exploration, it was discovered that these individuals had ADHD as an accompanying disorder.

Thus, among female clients, clinical providers may attribute ADHD symptoms to co-occurring mental health conditions that are more commonly diagnosed in women, such as anxiety and depression, rather than recognizing ADHD as the primary condition (Quinn & Madhoo, 2014). This leads to a focus on managing co-occurring disorders, like depression or anxiety, while ADHD remains undiagnosed. Additionally, women with ADHD often experience a higher prevalence of conditions like premenstrual dysphoric disorder (PMDD) and postpartum depression (PPD), with 45.5% of women with ADHD reporting PMDD symptoms compared to 28.7% in the general population (Dorani et al., 2021) further complicating the clinical picture. It is possible that clinicians may focus on the co-occurring disorder and miss the presence of ADHD among women. In sum, the overlapping symptoms of ADHD with other mental health conditions can distract clinicians from identifying ADHD as the primary concern in women. Instead, attention may be focused on more gender-specific concerns, resulting in a missed or delayed diagnosis of ADHD.

ADHD Among Black Women

Despite evidence that ADHD symptoms typically emerge in childhood and often cause impairments that persist well into adulthood (Faraone et al., 2006), there are some marginalized groups that are more likely to remain undiagnosed or receive a delayed diagnosis as adults (Waite, 2007). For example, due to a variety of reasons, Black women are more likely to have a later diagnosis or a missed diagnosis of ADHD when compared to other groups across the lifespan (Waite, 2007). This delay is driven by a combination of factors, including racial and gender biases in both clinical assessment and societal perceptions of ADHD (Waite & Ramsay, 2010). For example, the DSM-5 criteria for ADHD, which emphasizes observable behaviors such as hyperactivity and difficulty sitting still (APA, 2013), may not capture the more subtle and culturally influenced ways ADHD manifests in adults, especially Black women.

One of the primary factors for the delay in diagnosis of ADHD among Black women is the lack of culturally diverse research samples in ADHD studies (Waite & Ramsay, 2010). Waite and Ramsay (2010) emphasized the significant gap in data on ADHD within diverse populations, including Black women. For instance, cultural norms and background can influence societal responses to ADHD, including parenting styles, potentially causing further impairment in other domains (Waite & Ramsay, 2010). Despite the well-documented impact that ADHD can have on relationships (Attoe & Climie, 2023), education (Fletcher, 2013), and psychological well-being (Okumura et al., 2019), Black women are often not represented in these studies, thus limiting the application of findings to this group (Waite & Ramsay, 2010). As a result, there is insufficient information on how ADHD uniquely manifests among Black women, making it hard to identify if the disorder presents differently than more researched groups. This gap in research not only delays diagnosis but can heighten the negative effects of undiagnosed ADHD. Understanding these effects is essential to addressing the broader mental health and social challenges Black women face when their ADHD remains undiagnosed.

Negative Effects of Undiagnosed ADHD in Black Women

Despite growing recognition and awareness of how undiagnosed ADHD can significantly impair adult functioning (Quinn & Madhoo, 2014), the specific experiences of Black women who remain undiagnosed into adulthood continue to be overlooked in both research and clinical practice (Waite & Ramsay, 2010). The experience of undiagnosed can negatively affect Black women in three critical areas: educational and occupational outcomes, interpersonal relationships, and psychological well-being. Considering how these impairments intersect with existing racial and gender barriers, it is important to explore how undiagnosed ADHD specifically impacts Black women's lives and functioning across these domains.

Education and Occupational Impacts

Studies have found that children with ADHD typically struggle with concentration, remembering to turn in assignments, and time management skills, which can have long-term effects that persist into adulthood (Barkley et al., 2006; Fuller-Thomson et al., 2016; Quinn, 2005). Even when symptoms of ADHD appear to decrease as an individual ages, the lingering negative effects of impulsivity and inattention often make it challenging to catch up academically later in life (Barkley et al., 2006). This low academic performance has been shown to increase rates of unemployment among adults, resulting in lower income levels for adults with ADHD compared to peers of the same age (Fletcher, 2013).

While these academic struggles have been extensively explored (Kuriyan et al., 2012; Morley & Tyrrell, 2023), studies have largely focused on children (Fredriksen et al., 2014; Loe & Feldman, 2007), adolescents (Schmengler et al., 2023), and college students (Henning et al., 2021; Sedgwick-Müller et al., 2022). This leaves a gap in understanding how Black women who receive a late ADHD diagnosis experience the cumulative effects of childhood academic challenges in situations in which they are not diagnosed with ADHD until adulthood.

The impact of undiagnosed ADHD extends beyond education and into the workplace, where untreated symptoms of ADHD can cause significant functional impairments in job performance and career advancement (De Graaf et al., 2008). Most work environments can require higher levels of organization, attention to detail, punctuality, and time management skills, areas where individuals with ADHD often struggle (Schreuer & Dorot, 2017). In less structured environments where self-starting qualities are necessary, the executive functioning challenges that accompany undiagnosed ADHD can lead to additional difficulties (Christiansen et al., 2021), such as trouble maintaining employment and more frequent job changes than their peers (Schreuer & Dorot, 2017). Furthermore, in a review of longitudinal studies, Christiansen et al. (2021) found that even women who were diagnosed with ADHD in childhood still experienced lower employment outcomes, which included lower income, educational attainment, and lower-ranking jobs, even when controlling for other psychiatric disorders. These findings suggest that the consequences of ADHD are significant even with early diagnosis, indicating that women diagnosed as adults may face even greater obstacles in securing successful employment outcomes.

In addition, occupational challenges for Black women with undiagnosed ADHD are further complicated by racial and gender discrimination in the workplace (Abramovitz & Zelnick, 2021). Black women often face disproportionate criticism from supervisors, receive lower pay, and experience limited opportunities for professional development and additional training (Abramovitz & Zelnick, 2021). These systemic inequities, combined with undiagnosed ADHD symptoms, can create significant barriers to career advancement. However, research on how these intersecting factors impact Black women with undiagnosed ADHD remains limited. More focused research is needed to fully understand Black women's unique educational and occupational experiences in the context of a delayed ADHD diagnosis and racial and gender disparities.

Interpersonal Relationships

Undiagnosed ADHD in adult women can lead to significant difficulties in romantic, family, and interpersonal relationships (Attoe & Climie, 2023). Previous research suggests that symptoms of undiagnosed ADHD in adults may prevent them from forming and maintaining interpersonal relationships (Baran Tatar et al., 2015; Holthe & Langvik, 2017; Zambo, 2008). Specifically, adults with ADHD often experience relational instability, including higher divorce rates, shorter relationship lengths, and marital dissatisfaction, mainly due to the core symptoms of inattention, hyperactivity, and impulsivity that persist into adulthood (Wozniak, 2022). For instance, in a qualitative study conducted by Stenner et al. (2019), adult women with a formal or self-diagnosed ADHD, reported frequent experiences of being criticized and misunderstood by family members. However, the study did not provide any demographic information such as race, ethnicity, or socioeconomic status. Similarly, adult women in a study conducted by Holthe and Langvik (2017), which included five highly educated women aged 32-50, all diagnosed with ADHD in adulthood, expressed difficulties with social interactions due to emotional regulation issues, which strained relationships, but also did not mention any racial or ethnic demographics. Finally, in a study that explored the experiences of White and Hispanic adult women diagnosed with ADHD after the age of 60, participants expressed feeling rejected by peers and feeling different from others across their lifespan due to their undiagnosed ADHD symptoms (Henry & Jones, 2011).

Parenting also presents unique challenges for women diagnosed with ADHD as an adult (Holthe & Langvik, 2017). In a study exploring the experiences of women diagnosed with ADHD as adults, participants reported that their ADHD symptoms became more pronounced after having children, noting that the constant parenting demands and frequent interruptions made it harder to remain focused (Holthe & Langvik, 2017). It is important to note that racial demographic information was not accounted for in this study, leaving the specific implications for Black women unclear (Holthe & Langvik, 2017). Similarly, in their qualitative study, Henry and Jones (2011) found that women diagnosed with ADHD in adulthood faced social difficulties, social anxiety, and rejection due to undiagnosed symptoms. The sample in this study consisted of nine adult women, with seven identifying as White and the remaining two identifying as Hispanic, highlighting the lack of representation of Black women in ADHD related research.

While it has been well documented that ADHD symptoms, whether diagnosed or undiagnosed, can have significant negative impacts on interpersonal relationships (Henry & Jones, 2011; Holthe & Langvik, 2017), the majority of studies in this area either do not include Black women in the sample or fail to adequately represent and identify the number of Black women in their samples. As authors have suggested, ADHD must be understood within broader frameworks to be fully explored (Holthe & Langvik, 2017). Given that ADHD is shaped by the social and cultural context in which it exists (Horton-Salway & Davies, 2018), understanding the impact of gender and race is crucial.

Psychological Impacts

Along with other negative effects, undiagnosed ADHD is associated with significant psychological impairments, affecting both children and adults (Okumura et al., 2019). In adults, undiagnosed ADHD not only results in behavioral and attention difficulties, but also significantly impacts mental health and overall quality of life (Zhang et al., 2021). In their follow-up study, Okumura et al. (2019) found that children with undiagnosed ADHD symptoms, categorized through parent-reported information and behavioral assessments, experienced higher levels of depression, lower self-esteem, and more conduct problems than children who did not have ADHD. Notably, 83.5% of the children in that study with persistent ADHD symptoms had no formal diagnosis, suggesting that these issues likely persisted into adulthood and led to further psychological impairment. Adults diagnosed with ADHD later in life often report lower satisfaction with their childhoods and are more likely to suffer from depression and anxiety, partly due to being misperceived as lazy or unmotivated by teachers and caregivers during their earlier years (Rucklidge et al., 2007).

Research also highlights the heightened risks associated with a late ADHD diagnosis among women (Biederman et al., 2008; Henry & Jones, 2011). Specifically, scholars have found that women diagnosed with ADHD in adulthood are at a greater risk of developing major depression, with more severe and longer-lasting episodes than women without ADHD (Biederman et al., 2008; Powell et al., 2021). For instance, a study by Henry and Hill-Jones (2011) found that all the women in their sample who received a late diagnosis of ADHD were also diagnosed with co-occurring depression. Furthermore, 77% of these women were diagnosed with anxiety and 22% with bipolar disorder. These findings are compounded by evidence that the risk of premature death is significantly higher for individuals with ADHD, particularly those diagnosed later in life, due to factors such as accidents, injuries, psychiatric comorbidities, and health issues (Sun et al., 2019).

The findings related to ADHD and self-esteem are mixed. Although some research studies have either not accounted for gender (Michielsen et al., 2015; Newark et al., 2012) or found limited differences in gender when studying adult ADHD and self-esteem (Cook et al., 2014; Pedersen et al., 2024), research exploring the unique impacts of ADHD in young girls and women (Bauermeister et al., 2007; Ek et al., 2008) suggest that women with ADHD may face a heightened impact to their self-esteem due to societal expectations and gender norms (Quinn, 2005; Holthe & Langvik, 2017; Young et al., 2020). These findings illustrate the heightened vulnerability to multiple mental health disorders among women with undiagnosed ADHD, which can exacerbate their overall psychological distress and complicate treatment strategies. However, much of this research has not adequately included Black women, leaving a critical gap in understanding how undiagnosed ADHD impacts this population specifically. Given the intersection of race, gender, and late ADHD diagnosis, there is an urgent need for research focused on Black women to better understand their unique experiences and to develop effective interventions that address these compounded challenges.

Purpose of the Study

Black women face compounding challenges when seeking mental health services, specifically assessment and treatment for ADHD (Waite & Ivey, 2009). For Black women, these impacts are uniquely shaped by the intersection of race and gender yet remain understudied. Diagnostic challenges, paired with the intersection of multiple marginalized identities, further complicate assessing and diagnosing Black women with ADHD, resulting in late diagnosis and misdiagnosis among members of this marginalized group (Bailey et al., 2014). Both external and internal barriers, such as cultural stigma, controlling images, the Strong Black Woman schema, and a deep-seated mistrust of health care providers, contribute to the reluctance of Black women to engage with mental health services. In a study exploring public attitudes about ADHD, Black women, along with other non-white minority populations, were less likely to have heard of ADHD as a diagnosis (McLeod et al., 2007). Moreover, Black women and other Black individuals were less likely to believe that ADHD was a real disorder (McLeod et al., 2007). Notably, older participants were also less likely to have heard about ADHD (McLeod et al., 2007). This lack of awareness, in addition to the questioning of ADHD as an official diagnosis, creates additional challenges for Black women who could benefit from getting appropriately assessed and treated for ADHD as soon as symptoms emerge.

The consequences of undiagnosed ADHD are far-reaching and can cause significant consequences in academic, professional, and personal areas of life. Considering the barriers to accessing mental health services (Gara et al., 2019), the underutilization of these services by Black women (González et al., 2010), and the detrimental impacts of undiagnosed ADHD (Quinn & Madhoo, 2014), it is crucial to explore how these issues intersect to create distinct challenges for Black women who receive an ADHD diagnosis as an adult. The existing literature lacks a critical understanding of the unique experiences of Black women who remained undiagnosed with ADHD until they were adults. A thorough review of the literature has shown that there have been repeated calls from scholars for more attention to and empirical inquiry of diverse cultural and racial populations in ADHD research (Abdelnour et al., 2022; Bussing et al., 2012; Waite & Ivey, 2009). Specifically, the inclusion of diverse participants in research can significantly improve treatment effectiveness (Soto et al., 2018). However, despite these calls, there still remains a significant gap in published literature specifically exploring the lived experiences of Black women with undiagnosed ADHD. Without this understanding, the needs of this population may remain unmet, potentially exacerbating the challenges they encounter in different areas of their lives. While existing studies have provided important insights into the experiences of adult women diagnosed with ADHD (Henry & Jones, 2011; Holthe & Langvik, 2017; Stenner et al., 2019), they often fail to capture the unique and nuanced challenges created by structural and systemic gender and racial biases, particularly within the United States.

Therefore, the purpose of this study is to explore the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. Specifically, this research aims to understand how receiving a diagnosis later in life has impacted the personal, social, and professional lives of Black women. By exploring the unique experiences and meaning-making processes faced by Black women with undiagnosed ADHD, this study seeks to highlight their specific needs and contribute to the development of more inclusive and culturally sensitive mental health practices. To this end, the research question guiding this study is: What are the lived experiences of Black women who remained undiagnosed with ADHD until adulthood?

Chapter Summary

This chapter has provided a thorough exploration of the unique challenges Black women face in receiving an ADHD diagnosis and the broader implications of a delayed or missed diagnosis. This chapter explored how harmful controlling images and stereotypes such as the Angry Black Woman and the Strong Black Woman schema complicate these challenges by creating internal and external barriers to seeking mental health care. Additionally, the Strong Black Woman schema, while at times viewed as a source of empowerment, can also be equally as detrimental by reinforcing the idea that Black women struggle with their mental health challenges silently or independently without acknowledging vulnerability or pain (Woods-Giscombe, 2010). This internalization can lead to increased rates of depression, anxiety, and the underreporting of mental health symptoms (Watson-Singleton et al., 2019).

A central theme throughout this chapter has been the lack of culturally diverse research samples in ADHD studies, which has contributed to the underrepresentation of Black women in the research, which can lead to ineffective or inappropriate services. Waite and Ramsay (2010) emphasized this gap in the literature, suggesting that cultural norms and societal responses to ADHD can significantly influence the mental health outcomes in Black women. The lack of research on how late diagnoses of ADHD uniquely impacts Black women, combined with the societal pressures to conform to or disprove these stereotypes, has resulted in significant gaps in understanding the most effective approaches for diagnosis and treatment. These gaps are magnified by the lack of culturally sensitive diagnostic tools that take the intersection of race, gender, and mental health into consideration (Waite & Ivey, 2009).

Without culturally sensitive diagnostic assessments and research, Black women will continue to be overlooked in ADHD diagnosis and limited in their access to effective care (Waite & Ivey, 2009). The need for further research to address these crucial gaps was emphasized throughout this literature review to not only highlight the need to improve ADHD recognition and diagnosis in Black women but also to provide mental health interventions that acknowledge cultural and societal barriers that have impacted their experiences. This proposed study, grounded in Intersectionality and Black Feminist Thought, aims to address a critical gap in the literature by centering the voices of Black women and documenting their experiences of living with undiagnosed ADHD until adulthood. Specifically, this study explores how the unique interplay of race, gender, and mental health influences Black women’s experiences.

CHAPTER 3

METHODOLOGY

The aim of this qualitative study was to explore the lived experiences of Black women who remained undiagnosed with ADHD until adulthood, with particular attention to how this delayed diagnosis shaped their life experiences. Drawing on Intersectionality and Black Feminist Thought (BFT) as the integrated theoretical lens, this study sought to understand how the intersection of race, gender, and mental health influenced both the delay in receiving an ADHD diagnosis and the impact of living with undiagnosed ADHD. Considering this study's focus on meaning-making and personal experience of living with undiagnosed ADHD and intersectional identities, a qualitative approach fit best to explore this complex phenomenon. Specifically, Interpretive Phenomenological Analysis (IPA) was the appropriate methodological framework for this study as it specifically focuses on how individuals make sense of and perceive their personal experiences (Smith et al., 2009). This chapter outlined the methodology utilized during this study, detailing the research design and rationale, sampling and recruitment procedures, data collection, and methods of analysis. This chapter also includes the methods used to establish trustworthiness and describe a priori limitations.

Research Question

The research question that guided this study was:

1. What are the lived experiences of Black women who remained undiagnosed with ADHD until adulthood?

With this question, I explored how Black women interpreted and made meaning of their experiences living with undiagnosed ADHD prior to receiving their adult diagnosis.

Research Design

A qualitative research design was the most appropriate method for this study because it allowed for an in-depth exploration of complex phenomena and subjective experiences (Austin & Sutton, 2014). Ontologically, this study was grounded in a critical realist approach (Bergin et al., 2008), acknowledging that while ADHD exists as a diagnosable condition, its manifestation and impact are experienced by multiple truths shaped by the individual's contexts (Horton-Salway & Davies, 2018). From a constructivist/ interpretivist epistemological position, this study acknowledged that knowledge is understood to be subjectively constructed, making qualitative inquiry particularly useful to understand how individuals interpret their experiences, construct their realities, and attribute meaning to those experiences (Merriam & Tisdell, 2015).

The study's subjectivist axiological stance recognized that the values of both the researcher and the participants were essential to the research process. This philosophical foundation, situated within a constructivist paradigm, called for a qualitative approach that allowed for the rich, detailed exploration of an identified phenomenon, extending beyond what could be captured in a quantitative study alone (Creswell, 2013). Thus, these philosophical stances aligned with a constructivist paradigm, the use of qualitative research methodologies, and specifically, the phenomenological tradition.

Among different types of phenomenology, IPA was most appropriate as it allowed for an in-depth exploration of the participants' experiences while acknowledging the intersecting influences of gender, race, and a mental health condition. While there has been an increasing number of phenomenological studies focused on adult ADHD in women (Holthe & Langvik, 2017; Henry & Jones, 2011; Stenner et al., 2019), these studies did not specifically address how Black women experience ADHD within the context of race and gender. Therefore, given the complex interplay of race, gender, and ADHD, a more interpretive approach was needed to fully understand how larger cultural and structural factors shaped these experiences. For these reasons, IPA was the most appropriate qualitative tradition to understand the nuanced experiences of Black women living with undiagnosed ADHD.

Interpretive Phenomenological Analysis

IPA is a qualitative research method that integrates phenomenology, hermeneutics, and idiography and focuses on how individuals perceive and interpret their experiences (Pietkiewicz & Smith, 2014). IPA draws heavily on phenomenology, which is a philosophical approach that is used to describe the essence of experiences as they are perceived by individuals (Neubauer et al., 2019). IPA is also rooted in hermeneutics theory of interpretation and emphasizes that understanding a person's experience is inevitably influenced by interpretation (Smith et al., 2009). Unlike other qualitative approaches, IPA not only focuses on the descriptions of experiences, but also on the interpretation of how individuals make meaning out of these experiences (Pietkiewicz & Smith, 2014). The idiographic component of IPA highlights a detailed, in-depth analysis of individual experiences before moving on to explore more general commonalities.

IPA in Mental Health Research

IPA has been widely used in mental health research to understand complex psychological phenomena, including anxiety (McManus et al., 2014), depression (Rhodes et al., 2018), and emotions (Eatough & Smith, 2006). For instance, Eatough and Smith (2006) explored the complex process of making sense of emotions, specifically anger, and how meaning can be both an individual and social process combining cultural discourses and personal experiences. In another study, Rhodes et al. (2018) used IPA to investigate how chronic depression affects motivation and the sense of self, uncovering participants' experiences of emptiness, disconnection, and numbing along with episodic despair and feelings of entrapment. Additionally, the study emphasized the cultural and contextual influences that shaped how participants understood and interpreted their depression (Rhodes et al., 2018).

IPA also serves as a valuable method for uncovering in-depth hidden stories for marginalized populations and voices that are often overlooked by focusing on the lived experiences and systemic issues affecting them (Abdellatif & Haynes, 2024). For example, Thorpe et al. (2022) revealed that various sociocultural factors, such as a limited number of suitable partners, economic disparities, stereotypes, and controlling images, contribute to sexual anxiety experienced by Black women. Through the use of IPA, the authors uncovered rich, detailed accounts of sexual anxiety, which included cognitive, somatic, and emotional aspects. Similarly, Wallace et al. (2023) utilized IPA to explore how Black women who identify with the Strong Black Woman (SBW) schema make sense of their wellness experiences within a cultural context. This study revealed that cultural norms around prioritizing self-sacrifice and strength shape these women's experiences of wellness and self-care, reflecting both pride and burden. Therefore, IPA was well-suited to understand the lived experiences and hidden stories of marginalized populations, including Black women.

IPA and the Current Study

Along with previous authors who used IPA to understand experiences and interpretation of experiences among marginalized groups, this study employed IPA to explore the experiences of how Black women made meaning of their experiences living with undiagnosed ADHD, prior to receiving their diagnosis as an adult. ADHD manifests differently across individuals (Riccio et al., 2005; Young et al., 2020), and the intersection of race and gender may further complicate the experience of living with undiagnosed ADHD due to the unique cultural and structural challenges (Waite & Ivey, 2009). IPA was chosen as the most appropriate methodological approach for this study because of its emphasis on understanding the unique lived experiences of participants and how individuals make sense of their experiences (Smith & Nizza, 2022). The focus of this current study was to uncover how Black women understood and interpreted their experiences living with undiagnosed ADHD and IPA provided a framework that aligned with this goal, allowing for a deep exploration into the depth and complexity of individual experiences.

The core tenets of IPA, including phenomenology, hermeneutics, and idiography, were valuable to this study because they highlighted the subjective meaning-making process of individuals as they navigated significant life events (Neubauer et al., 2019). Living with undiagnosed ADHD until adulthood presented unique and often significant challenges, particularly for Black women who often face additional barriers and stigma related to a mental health diagnosis (Watson-Singleton et al., 2019; Woods-Giscombé, 2010). The interpretive aspect of IPA acknowledged that Black women's experiences cannot be viewed as objective or neutral. Instead, IPA invited both the researcher and the participants to engage in a process of sense-making, exploring how these women understood their pre-diagnosis experiences and interpreted their journey to diagnosis, considering the intersection of race, gender, and mental health (Smith & Nizza, 2022). IPA also provided space for Black women to construct new meanings of their experiences by challenging controlling images and creating social justice changes (Collins, 2002).

By using IPA, this research aimed to uncover how these women made sense of their experiences living with undiagnosed ADHD, how sociocultural factors influenced their path to diagnosis, and how they navigated challenges associated with unrecognized ADHD symptoms in the context of race, gender, and mental health. This approach guided both the collection and interpretation of data and ensured the lived experiences were explored within their full sociocultural context. In sum, IPA was the most appropriate methodological framework for this study as it allowed for a detailed analysis of the complex, intersectional experiences of Black women who lived with undiagnosed ADHD until adulthood.

Theoretical Framework

This study utilized an integrated theoretical framework that drew from both Intersectionality theory and Black Feminist Thought (BFT) to explore how a late ADHD diagnosis impacted the overall experience of Black women. These theories were important in contextualizing the unique challenges women faced in navigating mental health services, particularly in relation to their experiences of ADHD.

Intersectionality and Black Feminist Thought

By centering the voices of Black women, this integrated approach recognized that experiences of undiagnosed ADHD are not all the same. but were shaped by overlapping symptoms of oppression, including racism, sexism, and classism (Collins, 2009). By utilizing an integrated approach, this study aimed to offer a more comprehensive and holistic view of late diagnosed ADHD in Black women, not as a disorder in isolation but as one that is interconnected with other aspects of their identities (Settles, 2006). BFT emphasized the importance of self-definition and the diversity of Black women's experiences, while Intersectionality provided a lens to analyze how their intersecting identities influenced the way their ADHD symptoms were perceived and treated within societal and healthcare settings. A foundational premise of BFT is that Black women hold a unique standpoint shaped by their shared experiences of oppression (Collins, 2009). Collins (2009) asserted that although Black women may face certain common challenges as a group, each woman's experience is unique and may be interpreted in different ways. This notion aligns with IPA's idiographic approach and reinforced its appropriateness for exploring the diverse and nuanced interpretations of Black women's experience with ADHD diagnosed later in life. The experiences may vary greatly, with some individuals interpreting ADHD as a strength while others viewed it as a source of impairment (Stenner et al., 2019) or a disability (Patton, 2009). This integrated theoretical framework, drawing from both Intersectionality theory and BFT, supported an in-depth exploration of how a late ADHD diagnosis impacted the overall experience of Black adult women.

Role of the Researcher and Reflexivity

In IPA, the researcher is considered essential and plays an active role in interpreting the data and making sense of the participant's lived experiences (Smith et al., 2009). Unlike other traditional qualitative methods that require researchers to bracket their biases and prioritize an objective report of the data, IPA engages in a double hermeneutic process (Neubauer et al., 2019). This process involves participants making sense of their own experiences while the researcher interprets how participants create meaning from these experiences (Neubauer et al., 2019; Pietkiewicz & Smith, 2014). The researcher does not serve as a passive observer but rather contributes to the depth of understanding by offering interpretation and insight (Smith et al., 2009).

In this study, the role of the researcher was to interpret the unique and nuanced ways in which participants understood their later ADHD diagnosis and how it intersected with their race and gender. While I, as the researcher, brought some level of prior knowledge to the study, IPA acknowledges the importance of approaching the topic with openness, without imposing preconceived views or theories (Smith et al., 2009). This balance allowed me to ask meaningful and contextually relevant questions that captured rich and detailed descriptions while remaining close to the participant's unique perspectives.

With regard to the current study, I adopted an insider position (Smith et al., 2009) as a Black woman with lived experiences related to this study's phenomenon. This insider position aided in giving me access to specific groups for recruitment and building rapport with the participants (Smith & Nizza, 2022). However, to avoid imposing beliefs and personal opinions on the participants' experiences, I engaged in intentional reflexive practices through journaling and took steps to ensure trustworthiness of the data (which will be further explained in a later section). In line with an IPA approach, it was important that I reflected on my background and relationship to this research topic (Smith & Osborn, 2008). To bring transparency to my role as a researcher, a positionality statement is included to highlight both the potential benefits and limitations of my insider position.

Positionality Statement

There is no doubt that my identities have shaped the way that I view and make sense of the world. As a Black, heterosexual woman with ADHD and a Licensed Professional Counselor who works with adult women with ADHD, I approached this research project with both a personal and professional perspective. Like my participants, I, too, was diagnosed with ADHD in my late 20s and experienced firsthand the psychological, financial, relational, and career-related challenges related to receiving a later diagnosis. My lived experience with ADHD not only shaped my understanding of the challenges Black women with undiagnosed ADHD faced but also sparked my curiosity about how these women made sense of their experiences, which may be different from my own.

Navigating the mental health system with a late diagnosis of ADHD was challenging, to say the least. When I first started noticing my symptoms, ADHD was nowhere on my radar. I had never known anyone around me who was diagnosed or openly talked about it. I had no idea where to go for an assessment or what treatment for ADHD even looked like. Once I finally found a provider to conduct my ADHD assessment, the computer tests seemed outdated and impersonal, and the standard ADHD screening did not scratch the surface of the complexity of my symptoms. The physician who did my initial consultation even questioned my diagnosis because I had completed a graduate-level program and was now starting my Ph.D. This skepticism caused me to doubt myself even more despite being sure of what I was experiencing. The assessment itself was costly and was not covered by insurance, along with the medication and frequent appointments, which were both ongoing expenses. These initial encounters highlighted the lack of culturally sensitive resources in the mental health system. If I had not been in an academic setting where I had access to research studies, I might have never learned about ADHD and the ways it impacts Black women.

Once I was diagnosed, finding effective and competent support brought on new challenges. I sought therapy to process my new reality, hoping to get some insight and understanding, and was met with. “We all have a little ADHD.” I immediately felt dismissed and minimized because there was no acknowledgment of the ways ADHD had disrupted every aspect of my life. I noticed a clear gap in mental health providers who could understand my unique experiences in two ways: there were very few providers who were both culturally competent and adequately trained in ADHD and even fewer who were Black woman professionals with this combined expertise. I realized early on that I needed to be selective about where I looked for advice or treatment related to productivity and executive functioning because many providers were unaware of ADHD and specifically how it manifests for Black women.

As I moved further into my academic and professional life, I hesitantly admit that I often worried that people would question my diagnosis because of what I had achieved, and I sometimes felt embarrassed to disclose my ADHD diagnosis because of the fear of being seen as incompetent, especially as a Black woman navigating White spaces. I noticed that many of the providers that serve Black communities were not Black themselves, and there was little information on how ADHD presents differently for us, considering our identities. These unfortunate realities demonstrated the gaps in resources that were available and tailored to Black women, and the limited resources that did exist often failed to make Black women feel safe, seen, and understood.

These experiences drove me to work toward filling these gaps. As Collins (2002) asserted, “For African American women, the listener most able to pierce the invisibility created by Black women’s objectification is another Black woman" (p. 104). This quote resonated deeply with me as I reflected on my research journey. I was aware that many Black women, like myself, navigated spaces where their neurodivergent experiences were invisible, misunderstood, or dismissed. My work was grounded in my belief that people are the experts of their own experiences, and I aimed to honor that through this research study. As a therapist, I was constantly engaged in the process of uncovering how others viewed the world through their unique lenses. I believe my role as a therapist allowed me to engage with the participants with empathy while valuing their personal stories and emotional connections that made each individual experience distinct.

My personal connection to this phenomenon influenced my methodological approach, such as selecting IPA for a more nuanced exploration of participants' lived experiences. During data collection, my positionality as a Black woman appeared to influence participants to share their experiences more openly, assuming that I fully understand their perspective. While this may have led to richer data, it was important that I remained aware of how these assumptions and my presence may have influenced the stories being shared. Although these similar salient identities allowed me to approach the data with a foundational understanding of gender and racial dynamics, I was vigilant that my interpretations reflected the participants' experiences, rather than pre-determined assumptions.

My own struggles with ADHD, particularly within the highly structured environments of academic research, deepened my commitment to exploring the experiences of Black women with ADHD in different contexts. The challenges I faced during this process, such as balancing academic expectations, managing ADHD, and navigating the internal and external pressures of being a Black woman in academia, strengthened my passion to bring visibility to the lived experiences of Black women with ADHD. My position as a researcher and therapist added to this work, allowing me to connect with my participants in a meaningful way while contributing to the growing body of literature that seeks to better understand the intersectional challenges of race, gender, and mental health.

Data Collection Methods

Participants

The inclusion criteria were selected for a focused exploration of the experiences of Black women who remained undiagnosed with ADHD until adulthood with intentional consideration for biological, cultural, and societal influences. The sample for this study consisted of 10 Black adult women aged 25 and older who were diagnosed with ADHD as an adult (18 years or older) and were raised in the United States. Research has shown that adult women with ADHD find difficulty managing work and family responsibilities, causing unique challenges in their lived experiences (Holthe & Langvik, 2017). The age range of 25 years old and older was chosen to capture the diverse range of adult experiences, specifically ones related to the roles and responsibilities often associated with being an adult (Leahy, 2018).

While adulthood is typically acknowledged as beginning at 18 years old, the decision to focus on adult women aged 25 and older was grounded in the aim to understand the unique challenges and gaps in support that this age group had regarding access to resources, compared to emerging adults. Much of the existing ADHD research centered on college students and emerging adults, typically aged 18-24 (Anastopoulos et al., 2021; Canu et al., 2020; Vasko et al., 2020), a population that often has access to centralized support and resources provided by academic environments (Álvarez-Godos et al., 2023; Lattie et al., 2019). While Rasmussen et al. (2024) highlighted the unique experiences, risks, and vulnerabilities emerging adults face during this transitional period, women aged 25 and older had their own vulnerabilities and risks during this stage of life, including the complexities of balancing work, family, and identity development without the structured support available during their earlier years. Therefore, it was crucial to explore the meaning-making process of Black women in this stage of life when seeking to examine their experience of living with undiagnosed ADHD until adulthood.

Additionally, to qualify as raised in the United States, participants must have lived in the United States from at least the age of five. This specific criterion was chosen to ensure that the majority of the participants’ early childhood socialization, education, and cultural experiences were received within the U.S. context and that they were exposed to U.S. cultural and societal norms during their developmental years. Studies indicated that societal attitudes toward ADHD can vary widely across cultures, potentially affecting both diagnosis and treatment (Horton-Salway & Davies, 2018; Waite & Ivey, 2009). As societal perceptions and cultural norms influence ADHD, it was crucial to consider how these factors impacted the experiences of Black women diagnosed with ADHD as adults who were raised in the United States.

Finally, this study specifically focused on participants who identified solely as Black and female, with a cisgender identity that matched their sex assigned at birth. Narrowing down the selection criteria to this specific population (i.e., Black women) was important because research had shown that the intersection of race and gender created unique experiences in healthcare settings that differed distinctly from both White women and Black men (Mays et al., 2007; Watson-Singleton et al., 2019). While individuals who are from a mixed racial background and identify as Black may share some similar experiences, research indicated that their lived experiences with racial identity, discrimination, and healthcare access often differed in meaningful ways from individuals who identified solely as Black (Franco & O'Brien, 2017; Shih & Sanchez, 2005). Therefore, this study focused specifically on individuals who identified solely as Black (with regard to their race) to maintain a more homogenous sample that allowed for deep exploration of their distinct experiences.

Additionally, the focus on cisgender women accounted for the research that indicated that hormonal differences significantly impacted ADHD symptom presentation and severity (Antoniou et al., 2021; Quinn & Madhoo, 2014). Black women's experiences with mental health diagnosis and treatment are uniquely shaped by cultural, historical, and societal factors, including gendered racism and the Strong Black Woman schema (Lewis et al., 2016; Woods-Giscombe, 2010). Therefore, this carefully defined selection criteria offered a rich source of data that centered Black women’s voices in ADHD literature while illuminating the complex intersectional experiences of living with undiagnosed ADHD. These perspectives had been historically overlooked yet were crucial for understanding the unique challenges faced by this population.

Recruitment Procedures

Participants were recruited through two Facebook support groups specifically created for Black adult women with ADHD, with members who lived in different locations across the United States. These groups were selected because they offered direct access to individuals who met the study criteria and could speak to the phenomenon being studied. Although the research design identified snowball sampling as a secondary recruitment strategy, this approach was not necessary, as recruitment through the Facebook groups was successful in yielding a sufficient sample of participants. This recruitment method reached individuals who shared rich, detailed accounts of their experiences living with undiagnosed ADHD (Smith & Nizza, 2022).

A recruitment post with a link to the Google demographic questionnaire form was sent out to the Facebook groups to gauge interest in the study and to ensure that potential participants met the inclusion criteria (i.e., Black, cisgender female, aged 25 or older, raised in the U.S., received an ADHD diagnosis at age 18 or older). The demographic questionnaire form included demographic questions beyond the inclusion criteria, such as the highest level of education completed, current employment status, marital status, and parental status. Questions related to their ADHD diagnosis included their age of diagnosis and the type of health care provider involved in the diagnosis process (e.g., psychiatrist, psychologist, primary care physician, licensed professional counselor, or nurse practitioner). This information provided context for understanding the participants' lived experiences and ensured a diverse representation of life circumstances within the sample while maintaining the homogeneity required for IPA methodology (Smith & Nizza, 2022).

Immediately following each interview, I completed a reflexive memo to capture initial observations, the interview process, and emerging insights. These memos helped document my early interpretations that later supported my analysis process. I maintained a reflexive journaling practice to track my initial reactions, insights, and potential connections to the research question. My research team met a total of eight times to review transcript coding, refine themes, and discuss alternative interpretations. I also had additional consultations with my dissertation chair to review developing clusters and themes. I consulted with peers to verify the accuracy of themes and ensure that the findings were clearly communicated. My reflexive journaling enhanced the trustworthiness of the analysis by increasing transparency around my interpretive decisions and created space for ongoing critical reflection of my assumptions throughout the research study.

Sampling Method

I recruited a homogenous sample through purposive sampling, which is ideal for an IPA approach (Smith & Nizza, 2022). Purposive sampling ensured that participants were selected based on their ability to provide insight into the phenomenon under study (Smith et al., 2009). While purposive sampling was central to IPA, it also aligned with BFT's focus on centering the voices and lived experiences of Black women as a specific group. This method was also valuable in recruiting a demographically specific sample while amplifying the voices of marginalized populations (Else-Quest et al., 2023).

IPA requires relatively small sample sizes to make time for the in-depth exploration of the participant's perceptions, as the researcher needs to spend an extensive amount of dedicated reading time to gain clarity on the phenomenon (Larkin & Thompson, 2011). Smith and Nizza

(2022) suggested a range of between 10-12 participants for doctoral-level research, as this allows the researcher to spend sufficient time reading, analyzing, and reflecting on the data to gain a deeper understanding of the phenomenon. By focusing on a small, homogenous sample, this study provided a detailed exploration of how Black women lived with undiagnosed ADHD until adulthood. While a qualitative IPA study is not intended to represent the experiences of all Black women diagnosed with ADHD as adults, it provided important information regarding the perceptions and meaning-making processes of the participants in this study. This approach ensured that the nuances within the shared identity of being a Black woman with ADHD diagnosed in adulthood were not lost, and variations in individual experiences were given the attention they deserved.

Data Collection

As stated by Smith and Nizza (2022), “a prerequisite for good research is good data” (p. 42). To collect rich, nuanced data that reflected the intersectional experiences of Black women diagnosed with ADHD as adults, a thorough interview guide was created following IPA principles and infused components of Intersectionality and Black Feminist Thought. The interview guide included a mix of structured and open-ended questions, allowing for flexibility and in-depth exploration of participants’ experiences (Merriam & Tisdell, 2015). After creating the interview guide, I reviewed each question to check for what Benner (1994) referred to as naturalist and conversational language. Benner argued that asking questions that are too scholarly or filled with jargon may take away the opportunity for the participants to use their own language, potentially minimizing the depth of their responses (Benner, 1994). My research team reviewed the interview guide to ensure that the questions were clear, culturally sensitive, and effectively crafted to evoke detailed descriptions. This approach aligned with BFT’s emphasis on centering Black women's voices and production of knowledge. Questions and relevant prompts were crafted to explore the intersections of race, gender, and undiagnosed ADHD.

When potential participants responded to the recruitment post on social media or by contacting me through email, I verified that they were eligible based on the study's criteria. Eligible participants were sent an email from me with a link to schedule their interview through Google Meet scheduling, giving participants flexibility in selecting a time that fit their schedule. Interviews took place virtually using a web-based platform called Google Meet. The virtual nature of conducting interviews on Zoom allowed for convenience and accessibility to partake in research, but there were potential challenges to a virtual approach, such as connectivity issues, the participant's lack of access to technology or WIFI, and possible difficulties in building rapport with participants (Archibald et al., 2019).

Each semi-structured interview lasted 60- 90 minutes to ensure the topic was explored in depth, which was consistent with Alase's (2018) recommendation for IPA interviews. This time frame allowed for a thorough exploration of participants' experiences while also being mindful of the participants' time (Alase, 2018). Each interview began with me verbally reviewing the informed consent form with the participant and answering any questions that they had about the consent process or the study itself. I then asked participants to choose a preferred pseudonym to use for the study to maintain confidentiality, and if they could not think of one, they were assigned one. I requested permission to record the interview and reviewed privacy and confidentiality procedures, explaining how the recordings would be used solely for the purpose of ensuring accurate transcription and analysis. Using the Google Meet platform, all interviews were audio and video recorded to document accurate responses and observations of verbal cues, which were valuable in the interpretive process. The Google Meet recordings were stored securely on a password-protected computer and backed up on an encrypted external drive. After the interview, the recordings were transcribed using Google Meets embedded transcription service. Once the transcription was complete, I manually reviewed the transcripts and made any necessary corrections to verify that the participants' words were captured accurately. This process ensured that the data was ready for thorough analysis.

Ethical Considerations

This study was reviewed and approved by the Institutional Review Board at the University of Georgia before any interviews were conducted. Once recruitment was completed and participants who met the criteria were selected and scheduled for an interview, they were sent an informed consent form using Adobe Sign, which ensured an easy consent process. Once participants signed the informed consent form, they were sent a copy for them to keep for their records.

Recognizing the potential power dynamics that were present in the research process and adhering to BFT principles, participants were sent the interview questions through email in advance. This allowed participants who faced unique challenges related to ADHD (French, 2023) to prepare as needed while simultaneously creating a comfortable environment where they could fully express their experiences (Smith & Nizza, 2022). To ensure the confidentiality of the participants, all electronic data was kept in a data-encrypted folder, and any printed copies of data were kept in a locked file cabinet at the researcher's home office. The transcripts and Zoom recordings were only able to be accessed by the researcher and designated members of the research team and were destroyed when the research study was complete.

Data Analysis

Although it has been noted that there is not one single way to conduct an IPA analysis (Smith & Nizza, 2022), Smith and Nizza (2022) provided a step-by-step systematic process that was easily replicated and was followed for this current study. The analysis remained iterative in nature, allowing key themes and interpretations to expand and unfold as the process continued.

IPA Step One: Reading and Exploratory Notes of Case One

The first step of IPA involved familiarizing myself with the data before engaging in a more detailed analysis. To establish consistency in approach and establish a shared understanding of the analysis process, my entire research team engaged in step one for the first transcript. Each team member, including myself, began by independently reading through a printed copy of the first participant's transcript at least once while simultaneously watching and listening to the Zoom recording. By doing this, we gained a deeper understanding of the participants' words, not only in text but also in terms of the emotional tone, pace, and the way they were spoken. While reading the transcript, each team member took exploratory notes of our initial reactions, observations, and reflections. These notes focused on key phrases, significant passages, and individual nonverbal cues that stood out as potentially meaningful. After the initial independent review of case one, the research team met for a debriefing session to discuss our initial impressions, share exploratory notes, and reflect on any emerging patterns that we observed.

IPA Step Two: Formulating Experiential Statements of Case One

After reading the transcript and writing our initial exploratory notes, the next step involved formulating experiential statements of the first transcript. The research team collectively aimed to capture the essence of the participant's lived experiences, focusing on the intersection of their identities as a Black woman who lived with undiagnosed ADHD until they were an adult. In this step, I, as the primary researcher, carefully reviewed my initial notes and the exploratory notes of each research team member. I paid close attention to the language the participants used, any emotional reactions, and the contextual factors that shaped their experiences. This process allowed me to intentionally consider how different aspects of identity and social structures interacted in the participant's life story.

As I formed these experiential statements, I took note of key phrases, recurring themes, and topics that seemed important to the participants' experience. Experiential statements were both specific, including relevant context, and conceptual to capture the psychological experiences present (Smith & Nizza, 2022). When defining experiential statements, my task was to pick up on any signs that the participants may not be explicitly saying and use them to reveal underlying psychological meanings. The team member selected as the secondary research member for this case reviewed the experiential statements I formulated and suggested revisions and additions as needed. Then, the designated research team member three provided feedback on the experiential statements, focusing on consistency and offering suggestions for rephrasing or clarity.

IPA Step Three: Finding Connections and Clustering Experiential Statements of Case One

In this step, I started by gathering all the experiential statements created by the research team from case one's interview into a comprehensive list and organized them using an Excel sheet. This method allowed the research team to see the statements all together, creating a more flexible view to identify and understand possible connections and patterns to begin clustering. The process of clustering involved grouping related statements together to start forming emerging themes. As I was clustering, I remained mindful that the groupings were influenced by my research question and my evolving understanding of the data. While clustering, I paid attention to any recurring themes relevant to the intersection of race, gender, and undiagnosed ADHD. As clusters started to form, I labeled them, keeping in mind that these initial labels may change as I move through my analysis. I also remained open to the possibility of sub-themes within larger groups, leaving room for alternative interpretations of the participants' experiences. I shared the clusters I formed with the other members of the research team to be reviewed so they could provide input and suggestions on themes and check for consistency with the original transcript. As a team, we discussed any alternative interpretations and reached a final consensus on the clustered groupings for case one.

IPA Step Four: Compiling The Table of Personal Experiential Themes of Case One

Once a connection and clustered experiential statements had been identified, I compiled a table of personal experiential themes of case one. This table synthesized the insights gained from the previous steps, organizing them into a structure that represented and highlighted the intersection of race, gender, and undiagnosed ADHD. I identified overarching themes that captured the participants’ experiences. Following this, I refined the themes, ensuring they were both specific yet broad enough to capture related experiences. A hierarchical structure was developed with overarching themes and subset themes to reflect the complex relationships between different aspects of the participant’s lived experiences. For each theme, I selected specific quotes that represented that theme to provide direct context from the participant’s voice. Each quote was accompanied by the corresponding page and line references, which made it easier to write and reflect on further during the analysis process. Incorporating Collins’ (2002) idea of self-definition, this step in the IPA process ensured that the participants defined their own narrative within the broader societal context. Self-definition was crucial in ensuring that Black women's experiences were not interpreted through external frameworks but instead honored their own agency in narrating their identity and experiences. Once the table was drafted, my research team met as a group to review the table and provide feedback on the overall structure and reflection on relevant themes to ensure that all interpretations aligned with the participant's voice.

IPA Step Five: Analyzing Other Cases

Once all of the steps outlined had been completed for the first case transcript, I, as the primary researcher, continued to analyze each transcript as the main analyst. The two other team members alternated roles as secondary analysts, responsible for providing additional perspectives to enhance the trustworthiness of the analysis. For each transcript, the team member assigned secondary analysts reviewed and verified the experiential statements that I identified in each transcript to ensure that they were an accurate reflection of the participant's experience. The other team member examined the summarized themes gathered from these statements and provided feedback to confirm that the themes were consistent with the transcript data. Throughout this process, the research team intentionally bracketed our knowledge about the former case to analyze each case independently and approach every case with a fresh perspective to capture each participant's nuanced experience. This process continued until we had a set of individual tables of personal experiential themes for each participant in the study.

IPA Step Six: Cross Case Analysis

After completing each individual analysis, my research team and I completed a cross-case analysis to explore common patterns, differences, and similarities between participants. This cross-case analysis began with a review of all the tables created for each individual case by the primary researcher. To determine which patterns were common, I examined themes that appear in at least half of the transcripts, but I also remained open to less frequent themes that might hold significant meaning in specific contexts or situations. While these unique themes might not have been broadly shared, this approach remained in line with Smith et al.'s (2009) emphasis on capturing both convergence and divergence, which ensured that the analysis reflected not just commonalities but also meaningful variations among participants.

In this step, the research team collaboratively engaged in a team meeting to compare themes across cases. During this meeting, each member contributed to identifying broader patterns and nuances, making suggestions for connections or divergences between themes. By ensuring that different perspectives were considered, this process strengthened the analysis with an aim to make the findings more credible. Following this team meeting, we worked together to create a final thematic table that organized and summarized broader themes and connections across participants. The table included superordinate theme names, subordinate themes, direct quotes that illustrated each theme, the line number the quote could be found, and the number of times each theme appeared across the participant transcripts. By following these steps, the cross-case analysis resulted in a detailed synthesis that honored the individuality of each participant while also capturing overarching themes across the study.

Methodological Integrity and Trustworthiness

To ensure the trustworthiness and quality of this IPA study, I incorporated multiple methods and strategies following Lincoln and Guba's (1986) criteria. Credibility was ensured through prolonged engagement with the data by multiple readings of the transcript and peer debriefing sessions. I met regularly with a diverse research team made up of two Licensed Professional Counselors with relevant expertise. One research team member was a White woman who was diagnosed with ADHD as an adult, and the second research team member was a Black woman who clinically works with Black women with ADHD. Together, we discussed emerging themes and interpretations, reviewed transcripts and theme tables, and explored alternative interpretations and potential biases. We met a total of 8 times to cross-check our interpretations, which added consistency and rigor.

To maintain dependability, I kept a detailed log of the analysis process as I went through the research project. This audit trail allowed for transparency of the research process and illustrated the evolution of my interpretations, including my initial impressions, thoughts on emerging patterns, and reflections on the clustering process for each case (Smith et al., 2009). In an effort to reduce bias and ensure confirmability, I engaged in reflexive journaling to track my thoughts, beliefs, and reflections throughout the data collection and analysis process. This practice allowed me to keep track of how my own perceptions influenced my work. Additionally, given that I, as the researcher, was more sensitive to certain aspects of the transcripts because of my background and personal experiences with the phenomenon, peer debriefing sessions provided the opportunity to challenge my interpretations and consider alternative viewpoints while minimizing researcher bias (Ahmed, 2024). To further enhance trustworthiness, I engaged in regular meetings with my dissertation chair throughout the data analysis process. These meetings provided additional oversight and guidance, ensured that my interpretations remained grounded in the data, and offered opportunities to discuss any potential biases that emerged.

To ensure authenticity, the accurate representation of the participants’ voices was the priority throughout this study. When presenting the findings, I provided thick descriptions of participants' experiences and included direct quotes. This allows the readers to evaluate the accuracy between the data and interpretations and make decisions on the relevance of the findings to their individual situations and contexts (Ahmed, 2024).

These strategies helped ensure that the findings were trustworthy and were an authentic representation of the participant’s lived experiences while also following the interpretive nature of IPA research. By implementing these methods, I aimed to conduct an accurate, in-depth, and trustworthy IPA study that honored the complexity of Black women's experiences who lived with undiagnosed ADHD until they were adults.

A Priori Limitation

In designing this study, I recognized that some limitations existed. First, recruiting participants primarily through Facebook support groups may have limited the variety of perspectives included in this study. Black women who are not members of these specific ADHD support groups or who do not use Facebook may not have had the opportunity to participate in this research study, potentially missing out on individuals who may be less engaged with social media or who seek support through alternative methods. While snowball sampling may have helped mitigate some of these recruitment limitations, the study’s virtual nature presents challenges of its own. The decision to conduct interviews exclusively online, including the demographic questionnaire and Zoom interviews, introduced additional limitations. Participants needed reliable internet access, which may have unintentionally excluded potential participants with limited or inconsistent internet connection. Furthermore, the virtual interview format at times posed technological difficulties that could have interrupted the interview process. Additionally, some participants may have struggled to find private, secure spaces to discuss sensitive topics related to their ADHD experiences, potentially impacting the participant’s comfort and willingness to share. These technological and privacy considerations may have inadvertently impacted the depth of these interviews.

Chapter Summary

In summary, this chapter has outlined the methodological methods that were used to explore the effects of undiagnosed ADHD on Black women who received their diagnosis in adulthood. Grounded in Intersectionality theory and BFT, this study utilized a qualitative approach to understand how undiagnosed ADHD shapes Black women's lived experiences across personal, professional, and social domains. IPA was chosen to answer this research question because it allowed for a detailed and in-depth exploration of the meaning-making processes central to the participants' experiences. This chapter detailed the research design, research procedure, and rationale for utilizing IPA including the sampling and recruitment strategies, data collection methods, and analysis procedures. This study sought to contribute to a deeper understanding of the unique challenges and insights of Black women living with undiagnosed ADHD, highlighting the need for more inclusive and culturally sensitive mental health practices.

CHAPTER 4

FINDINGS

The purpose of this study was to explore and understand the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. These findings presented in this chapter are based on the thorough analysis of in-depth semi-structured interviews conducted with ten Black women who received an ADHD diagnosis as adults (after the age of 18). Using Interpretive Phenomenological Analysis (IPA), I examined how the participants made sense of their experiences living with undiagnosed ADHD and the impact it had on their lives. This chapter begins with a description of the participants, followed by a presentation of the themes that were interpreted from the data analysis. Each theme is explored in detail and illuminates the unique and shared experiences of these women.

Description of Participants

Ten Black women who were diagnosed with ADHD in adulthood participated in this study. The participants ranged in age from 31 to 51 years old with the median age of 35 at the time of the interview. Participants were diagnosed with ADHD between the ages of 29 and 50, with the median age being 33. All participants were raised in the United States and reported living with undiagnosed ADHD throughout their childhood and into their adult years. Of the ten participants, four (40%) earned doctoral degrees, four (40%) earned master's degrees, and two (20%) earned bachelor's degrees. Of the 10 participants, eight (80%) were employed full-time, one (10%) was self-employed, and one (10%) was unemployed at the time of the interview. Two (20%) participants were married, two (20%) were divorced, and six (60%) were single and had never been married. Six (60%) participants had children, and four (40%) did not. Participants received their diagnosis from various healthcare providers. Four (40%) participants received their diagnosis from a psychiatrist, two (20%) from psychologists, two (20%) from psychiatric mental health nurses, one (10%) from a primary care physician, and one (10%) from a licensed professional counselor. Participant pseudonyms and contextual information can be found in Table 4.1.

Table 4.1

Participants Demographics

Pseudonym	**Age**	**Age of Diagnosis**	**Employment Status**	**Highest Degree**	**Children**	**Diagnosed By**
Alexis	47	36	Full Time	Doctoral Degree	Yes	Psychiatric Nurse
Rachel	41	40	Full time	Doctoral Degree	Yes	Psychiatrist
Ivy	35	35	Full time	Doctoral Degree	Yes	Psychologist
Tiffany	31	30	Full time	Master's Degree	No	Psychiatrist
Sheila	38	35	Self Employed	Master's Degree	Yes	Psychologist
Bailey	35	30	Full time	Doctoral Degree	No	LPC
Monay	32	30	Full time	Master's Degree	Yes	Primary Care Physician
Charity	33	31	Full time	Bachelor's Degree	No	Psychiatrist
Krystal	31	29	Full time	Master's Degree	No	Psychiatric Nurse
Deidra	51	50	Unemployed	Bachelor's Degree	Yes	Psychiatrist

1. The goal of this study was to center the voices of Black women while acknowledging shared experiences and honoring individual experiences. Specifically, I sought to answer

the question: What are the lived experiences of Black women who remained undiagnosed with ADHD until adulthood?

Presentation of Themes

Data analysis revealed six themes that developed from the participants' narratives. These themes captured the lived experiences of Black women who remained undiagnosed with ADHD until adulthood, as well as how the participants made sense of their experiences. The six themes are: (1) Misattributing Undiagnosed Symptoms to Identity, (2) Navigating the Pressure to Meet Impossible Standards, (3) Developing Complex Strategies to Cope, (4) Overlooking ADHD Due to Cultural and Social Misconceptions, (5) Fighting to Be Heard, and (6) Grieving the Loss of Missed Opportunities (see Table 4.2). The following sections will explore each theme in detail, focusing on the unique and shared experiences of these women through their own words and perspectives.

Table 4.2

Group Experiential Themes

Major Theme	**Subtheme**
Misattributing Undiagnosed Symptoms to Identity	
Navigating the Pressure to Meet Impossible Standards	
Developing Complex Strategies to Cope	
Overlooking ADHD Due to Cultural and Social Misconceptions	Normalcy of ADHD Traits Within Family Dynamics
Fighting to Be Heard	
Grieving the Loss of Missed Opportunities	

Theme One: Misattributing Undiagnosed Symptoms to Identity

"I just thought you just have to try harder. I didn't think there was anything else going on, I just was like you're just not smart enough" (Krystal)

The theme, Misattributing Undiagnosed Symptoms to Identity, describes how participants misattributed the challenges brought on by undiagnosed ADHD to their identities. Before receiving a formal diagnosis, participants attempted to make sense of their difficulties without having ADHD as an explanation. Without this official explanation, participants and others negatively interpreted their symptoms as personal failures and character flaws, which led to deep-seated feelings of self-blame and shame that shaped their sense of worth and identity. For the Black women in this study, these ADHD symptoms were often viewed through racial and gendered stereotypes, which further intertwined symptoms with their identity.

Before receiving an official ADHD diagnosis, all participants described wrestling with confusion over their cognitive and behavioral symptoms and struggling to understand why they found certain tasks so difficult. For example, Rachel described her confusion about memory and difficulties staying on topic by stating, "The memory issues…I just didn't know what was wrong with me, like why am I getting stuck in the middle of a sentence?" Additionally, Krystal shared similar frustrations related to her reading challenges and said, "I did struggle. I would read the page over and over again, and I would read it, and I was like, I don't even know what I just read. But I didn't know why this was happening."

Without a diagnosis to explain these challenges, participants began to question whether their struggles were part of their personality or if they were something deeper. Krystal reflects on this uncertainty:

> So, for me, I always kind of knew something was wrong, but at the same time, it was never something that I really like leaned into cuz I just figured I couldn't distinguish if something [else was] going on, or maybe I'm just a quirky person.

The process of merging ADHD symptoms into their sense of self became even more complicated when others also misinterpreted these behaviors, automatically assuming they were character traits or a lack of effort. Without a diagnosis or language to explain the participants' behaviors, parents, teachers, and colleagues often viewed their difficulties as laziness, carelessness, or recklessness. Bailey shared how her parents misinterpreted her symptoms as character traits and said, "My mom and dad used to say it's because I don't pay attention to detail, or they would say that basically I just don't care".

Moreover, what made others' negative perceptions and assumptions more damaging, was that they often confirmed the self-judgments participants were already harboring about themselves. When family members, teachers, and colleagues labeled them as lazy, careless, or unreliable, these external judgments reinforced participants' internal judgments, in which they assumed that their difficulties stemmed from personal shortcomings rather than an undiagnosed condition. For example, Sheila described how her mother's comments resonated with her own perceptions:

> But as a child, my mom always say, "you don't apply yourself" or "you can't make a decision," [or] "you're always jumping from one thing to another." And I did feel like that. Even for things that I really loved, I still would have a hard time… I would have a hard time really achieving it to the level that I wanted because I would get distracted and go to something else.

Sheila acknowledged that what her mother said about her struggle to stay focused felt true, but without understanding that these were symptoms of ADHD, she accepted the notion that these were flawed inherent character traits. This pattern appeared consistently among all participants; when negative perceptions and misunderstanding of their symptoms from others explained how they struggled internally, they accepted these attributes as parts of their identity. Without knowing about ADHD, participants more easily perceived these criticisms and judgments as truth.

Beyond family interactions, participants faced similar judgments in professional and educational environments. Krystal described how her difficulties with being on time, a common challenge for people with ADHD, led others to view her negatively. She said, “I always felt like it was unfair because, like me being tardy, I couldn't explain to them why I was tardy... and I just knew people thought of me as just so careless, [thinking] “what is wrong with this girl””?

For participants, these ADHD symptoms were often viewed through racial stereotypes contributing to harmful perceptions of Black women. This perpetuated cycle is illustrated through Deidre’s experience with emotional dysregulation:

> And then I was always angry, my emotions were so dysregulated, I was just always angry, and that affected me because I came across as this angry Black woman at work, which I was, but not because of work, but because of the ADHD and depression.

Without an understanding of how ADHD impacts emotion regulation, Deidre and others around her associated her behavior and disposition as characteristics associated with her race and gender.

Over time, participants started to adopt these external judgments and saw themselves through the negative perceptions of others. Alexis described reluctantly starting to view herself as unreliable, even though she knew that her tendency to forget was not intentional. She said, “I don't want to call myself a flake, but I would, I would flake on a lot of things, and it wasn't intentional. I would really just forget.” The tension in her statement shows her struggle of trying to explain her behaviors without the context of ADHD. Similarly, Bailey accepted her symptoms as part of her identity saying, “I seriously thought, I’m just forgetful."

For many participants, the gap between knowing they were intelligent and struggling to reach their potential added to their self-doubt and confusion about who they were. Sheila shared:

> So as a kid I always felt smart, but underachieving or like I had so much potential, but I had a hard time being able to actually achieve it or grasp that potential…you're like, I know to do these things, but I just forget to do them.

This internal conflict forced Sheila to question her sense of identity and what she was capable of doing. Similarly, Tiffany expressed how this discrepancy threatened her core identity:

> I've always kind of had this complex of, I felt good enough in a space where things were easy, but when it got hard, my identity as a smart girl was erased and it's like who the hell am I now?

Tiffany’s narrative demonstrates the significant impact of ADHD on her self-esteem and sense of identity, challenging her perception of her intelligence and her abilities. The existential questioning of “who the hell am I now” captures the identity confusion that undiagnosed ADHD created.

After years of unexplained symptoms and negative judgments and perceptions from others, many participants came to internalize the belief that they were fundamentally flawed or defective before receiving their diagnosis. Deidre shared how she internalized her lack of understanding saying, “I always felt broken. I just felt different and quirky… it just felt like I was just naturally broken, that I was just made wrong." These internalized beliefs significantly impacted participants' confidence and contributed to self-doubt about what they could accomplish. Tiffany spoke to this self-doubt regarding entrepreneurship:

> I think about entrepreneurship, but I don't trust myself to do that either because of my lack of organization or my lack of stick-to-it-ness. I feel wishy-washy, honestly, as a human. I feel wishy-washy cuz I do stuff and then I don't want to do it no more.

The theme of Misattributing Undiagnosed Symptoms to Identity illustrates the unique impact of undiagnosed ADHD on participants' self-perception. Specifically, undiagnosed ADHD symptoms affected critical aspects of development such as self-concept and identity formation among Black women in this study.

Theme Two: Navigating the Pressure to Meet Impossible Standards

"We received a message from the time that we're a child that you got to run twice as fast, you got to jump twice as high, and little do we know, it's three times cuz we have ADHD, there's this extra layer that we don't even know about" (Tiffany)

The theme, Navigating the Pressure to Meet Impossible Standards, captures the tension participants experienced as they attempted to meet the high expectations placed on Black women while simultaneously dealing with undiagnosed and unrecognized ADHD. Participants described feeling trapped between cultural demands to be twice as good and their internal struggles with undiagnosed ADHD symptoms, including focus, organization, and consistency. This intersection created a unique burden where the areas in which participants struggled the most seemed to overlap with the areas that required excellence due to their salient cultural identities. For example, ADHD symptoms directly conflicted with deeply ingrained expectations of Black womanhood, which affected participants' sense of worth and belonging. The compounding pressure from racial and gendered expectations along with ADHD created standards that were practically unrealistic to meet, yet participants described intense efforts to live up to these standards despite their undiagnosed challenges.

All participants spoke to the intense pressure of navigating the higher-than-normal expectations placed on Black women while living with undiagnosed ADHD. Krystal described the heightened expectations that are placed on Black women in leadership roles and professional spaces:

> The Black women there would be the superstars of leadership…and hard workers, and so, the bar is always so much higher of what you're expected to do. So, if you deviate from that even a little bit, it's like, what's wrong with you?

Krystal's experience highlights not only the pressures Black women face when trying to uphold higher work expectations but also the harsh judgment that follows when they do not meet these standards. Bailey shared this same challenge of trying to meet expectations around multi-tasking, which can be particularly difficult for people with ADHD:

> There's this high expectation for us to have to perform at multitasking and having ADHD and multitasking, I'm not saying it can't be done. It can, but that means that… your productivity level isn't at its best. You are forced to multitask or balance multiple things, and then also this idea that Black women have to get things done in this short amount of time too. [There's this] pressure of okay, no, I HAVE to do this because I got to be better, I got to exceed expectations.

Bailey's words reveal how the cultural pressure for Black women to be twice as good created nearly impossible standards for those with ADHD. This pressure was compounded by the fears about confirming negative stereotypes, as Alexis describes:

> Masking was probably the big thing, because I didn't want people to think as a Black woman, as a woman, or as a Black person, that I was lazy or that I was, you know, not capable [of] doing things. So, I masked a lot. I think the masking came a lot from not wanting to fit some stereotype.

Alexis' reflection highlights how the expectations placed on participants added to pressure to actively disprove harmful stereotypes about laziness or incompetence.

Many participants traced these expectations to intergenerational patterns and family dynamics. Bailey reflected on how high standards were reinforced in her upbringing as she said, "Looking back now...I think Black women are multitaskers. I mean, I grew up in a home where you get things done as a woman." Similarly, Deidre connected her experience to the generational patterns she witnessed growing up about being a multitasker and a caretaker:

> My grandmother was the oldest of nine ...and she had to take care of her siblings when she was four or five years old...her responsibility was to take care of the babies…so her whole life she was a caregiver. Even when she had her career, she still was a caregiver…she took all of that on while still raising a family, and I think back now that I'm diagnosed, it's like, oh damn, that's a lot of pressure.

Deidre's insight illuminates how receiving an ADHD diagnosis gave her a new perspective on these intense family patterns that are often passed down through generations in Black families, where caregiving responsibilities and the pressure to excel despite challenges are frequently embedded within cultural expectations of Black women. Without understanding ADHD, participants believed that these standards were reasonable and that they were just simply failing to meet them. Krystal directly addressed this gap between expectations and what she was realistically able to keep up with when she said, "The expectation of work ethic and work expectation is just different, and I realize it's not easy for me to keep that pace." Tiffany spoke to the weight of these expectations and her exhausting efforts to try to live up to them even when she was struggling. She said, "I have spent a lot of time trying to be the extraordinary Black girl that everybody said that I was, everybody thought that I was." For Deidre the pressure to excel became a destructive cycle tied to her self-worth:

> I felt the pressure to be excellent…and if I wasn't excellent, then that fed the narrative that I'm broken. But then that narrative that I'm broken fed me… fed the narrative that you got to push, you got to turn this B into an A. You got to be in all these different social groups. You got to apply to all these colleges. You got to get into all these colleges. You got to get all these scholarships. You have to get this good job, you have to make this amount of money to be successful. It just fed into it. Because with every failure, it was not just a failure, it was catastrophic because, oh my god, I'm broken. I'm not successful. I'll never be successful. But then you obsess and try to be successful.

Deidre's reflection illustrates how the pressure to be excellent was not just a personal goal, but it was an expectation tied to her worth and identity. Every accomplishment was about proving that she was not broken, and every setback reinforced deep fears of inadequacy from which she was trying to escape. For participants, the intersection of Black womanhood, societal standards, and undiagnosed ADHD created an impossible standard where failure was not an option.

Beyond professional achievement, participants described how undiagnosed ADHD symptoms affected their ability to meet gendered expectations at home. Tiffany shared how her struggles with organizations and cleanliness affected how she saw herself as a woman:

> As a Black woman, cleanliness is next to godliness. Like, that's what we're taught. And to be unclean, to be a messy Black woman who struggled with cleaning, definitely felt like a

> moral failure… definitely felt like a bad person, definitely felt like, how can I be someone's wife one day? As a woman, there's this expectation that I know how to keep house and that I'm domestic and I definitely dreaded that thought.

Tiffany’s reflection illustrates how her ADHD symptoms directly conflicted with cultural expectations placed on her as a Black woman. Her questions demonstrate how cultural expectations of Black womanhood were closely tied to her identity and value as a potential partner. Similarly, Ivy connected her household struggles to her identity as a wife and a mother:

> When I was forgetting things like the laundry or maybe I didn't clean up today and my house doesn't look that great, I'm feeling bad about myself and my worth and [that] I am less than because I'm not keeping up with these things.

For these participants, struggles with organization and household responsibilities were not simply about the tasks themselves, but represented moral failures and threatened their sense of worth as Black women.

Monay described the complex double-edged feeling of receiving praise for her accomplishments, which in some ways felt “like a high,” yet in other ways left her to struggle on her own. Even after asking for help and sharing that she was struggling, people still assumed she did not need help:

> I actually remember telling friends and my family one time where I was like I can't do this and they were like, “Of course you can, you always do!” And my friends were just like, “We don't help you because it just seems like you have your stuff together. You're always completing things and doing so good at it.” So, it's like I never got any type of help, but people would always be like, "Great job. Keep going."

Monay’s experience highlights how the high expectations that other people had about her created an isolating dynamic where her requests for support were minimized. Sheila spoke to this expectation and said, “The expectation is that we power through, we're wonder woman, we don't ever have issues. We can do everything.” Meanwhile, Rachel internalized the expectation of self-sufficiency:

> I'm a lone wolf that just does stuff and doesn't seek help. I don't know, it's just the oldest child in me. Like, it has to get to a point where I'm just frustrated for me to even think about asking anybody for help.

Together these experiences illustrate how the combination of undiagnosed ADHD and the cultural expectations placed on Black women created a uniquely challenging experience.

Several participants prioritized productivity to meet heightened expectations. Rachel described how this experience affected her college years:

> I just over-did everything, so it looks good to other people… I just had to super hyper focus on stuff instead of participating in normal life, being a normal college student and doing the normal college things, because I had to be hyper-focused on excelling.

Rachel’s reflection illustrates the pressure to excel according to cultural standards by revealing the trade-off between sacrificing typical social and college experiences in order to academically succeed. Monay similarly described a relentless internal pressure to do more:

> I always felt like I was being lazy, so I was like I need to do more…Even if it was just in my free time, I would just start learning things out of nowhere... it felt like I had to, I need to know more.

Monay’s tendency to constantly be productive even during her free time, reveals how deeply she had internalized the pressure to constantly prove her worth and intelligence and fight against the label of being lazy.

Theme Three: Developing Complex Strategies to Cope

“In my medication case, I have different medicines. I have it written down in my iPad: On Monday this is this pill, Tuesday this is this pill. I make notes of where things are, so I don't forget where I put them [and the] order that I do things like brush my teeth [and] take my contacts out. The way I do things at night and in the morning, it is literally organized in that way” (Bailey)

The theme, Developing Complex Strategies to Cope, captures the specific compensatory behaviors and strategic coping mechanisms Black women developed to manage their undiagnosed ADHD symptoms. Participants described creating elaborate systems, rigid routines, and masking techniques to manage symptoms they did not yet understand, while simultaneously protecting themselves from negative racial and gendered stereotypes. These compensatory behaviors emerged early in life and persisted through adulthood until they received their ADHD diagnosis. The extensive, detailed nature of their behaviors created complex patterns that both helped them function and masked their struggles from others. This theme focuses on the concrete behavioral adaptations that participants implemented in response to challenges from their undiagnosed ADHD.

Participants described unknowingly developing elaborate systems and rigid routines to manage their undiagnosed symptoms. Bailey described how her coping mechanism evolved into overly structured systems and behaviors that mirrored obsessive-compulsive disorder (OCD):

> The therapist said because of my [undiagnosed] ADHD I think I turned somewhat like OCD in a sense, where I mean I have systems for literally everything. When I come in the house, I have a system for where I put my keys so that I don't misplace them. I used to forget if I had locked my door or not, so, I got a Ring camera so I can [check remotely] instead of driving [back home], because this used to happen to me. I'd be five minutes from work and get anxious [wondering], did I leave the door unlocked or [leave] candles on in my house? So, I also have a camera in my house so I can check those things. And I have a ring [camera] on my door, so that I can go back and see, okay, wait, did I lock the door before I drive all the way home.

Bailey's complex systems were created to manage forgetfulness and offer a tangible sense of order and emotional relief. Similarly, Monay's extensive reliance on multiple calendars and planners illustrates her attempts to overcome forgetfulness and difficulties managing time:

> I got five calendars, one of them is in my phone. I got sticky notes around my house. I keep a journal, and there's also a calendar in my car. I also have a calendar in my office, and I have a calendar that's in my living room and I was using every single thing every single day, so I didn't forget things.

Similarly, Rachel relied on multiple organizational methods and acknowledged how these tools became her way of gaining some form of control:

> I made a bunch of lists and organizational things, a lot of them. Different programs, all kinds of planners and calendars and I can't say that I always use them efficiently, but that was my go-to way of figuring life out.

Participants also incorporated creative, yet demanding, methods to manage their struggles. Krystal described her creative workarounds to proactively manage her struggles with time:

> I knew I could not get anywhere on time to save my life, so, whenever LYFT and Uber became a thing, I would just schedule all my rides. I would just schedule them. As soon as I would agree to do something, I would schedule the ride so that way I know I will get there at a reasonable time.

Ivy described relying heavily on caffeine in an attempt to manage her attention and focus before recognizing them as ADHD symptoms:

> I run my life off of caffeine. By the time I get to work, I've had either a coffee with three to four espresso shots, and then by noon, I'm drinking a Monster or an energy drink. But it was to help me focus and I'm thinking I just need to be alert.

Her reliance on caffeine shows a clear behavioral adaptation as she attempted to gain control over her attention difficulties.

For Deidre, coping extended beyond managing tasks to extensively changing her behaviors and personality to cope with her undiagnosed ADHD symptoms:

> Masking was basically mirroring whoever I was hanging out with, whoever were my friends. I’m the funny girl. I'm the witty girl. So, being funny and witty, going out, socializing when I didn't necessarily feel like it… It was rough. I was always trying to mask what I thought was broken and try to fit in.

Deidre’s description shows how she adopted different roles to mask and compensate for underlying symptoms, despite the psychological and emotional toll it took on her. Charity specifically spoke to how the behavioral techniques she developed to cope simultaneously prevented her from receiving the support and understanding she needed. She said, “I knew what was socially acceptable behavior and what wasn't, and I was able to mask the things that would have got me diagnosed earlier.” Charity’s insight reveals how participants’ tactical behavioral adaptations, although they may have been effective in helping them function externally, ultimately prolonged their internal struggles by masking symptoms that may have signaled the need for professional support and recognition.

Several participants also described using excessive productivity and overworking behavioral strategies to manage symptoms such as distractibility, anxiety, and feelings of inadequacy related to their undiagnosed ADHD. Monay spoke to this experience, describing how implementing specific overworking behaviors became her primary coping method from an early age:

> I remember it would always feel like I would feel really bad really easy. I guess it was a lot of anxiety and a lot of depression since I was a kid because I always felt like I wasn't catching on to what other people were doing because I just felt bored, and then I would feel bad for being bored and get anxious. So, then, I would start overworking myself or trying to do more so I can catch up to everybody else.

Monay’s reflection reveals her deliberate use of overworking behaviors as a structured coping mechanism, illustrating how participants developed concrete productivity routines and work habits to compensate for their undiagnosed symptoms. This pattern of overworking as a deliberate behavioral adaptation also extended to professional settings. Alexis described specific compensatory behaviors she implemented in her workplace environment:

> I tried to make up for what I thought were my shortcomings by going over and above what I needed to do sometimes. At work, I might end up volunteering for more stuff than I needed to because I'm like, oh, I want them to know that I'm here, I'm a team player.

Alexis's reflection emphasizes how overworking served as a concrete coping strategy developed to visibly prove she is a "team player" and illustrates how she utilized overworking to make her contributions overly visible to counter any negative assumptions people may make of her.

These elaborate systems, compensatory and masking behaviors, illustrate the unique strategies participants developed to survive and function with undiagnosed ADHD. Participants appeared highly functional externally but spent significant effort behind the scenes to maintain this appearance. Their distinct yet exhausting adaptations and extensive coping strategies became so effective at hiding their symptoms that they often delayed diagnosis. Together these experiences highlight the complex strategies and resourceful coping mechanisms the Black women in this study used to manage undiagnosed ADHD developed to function in their daily lives.

Theme Four: Overlooking ADHD Due to Cultural and Social Misconceptions

"I didn't think it was ADHD because I was like, it's not like I'm someone who can't sit still or struggled to pay attention" (Bailey)

The participants' experiences revealed a complex journey toward recognizing and diagnosing ADHD. The theme, Overlooking ADHD Due to Cultural and Social Misconceptions**,** captures how cultural narratives and social misconceptions about ADHD contributed to participants overlooking or dismissing their symptoms despite experiencing them throughout their lives. Within this theme, a significant sub-theme was identified: Normalcy of ADHD Traits Within Family Dynamics, which highlights how the commonality of ADHD-related behaviors within family systems created an additional barrier to recognition. Participants described multiple factors that obscured their ability to identify their experiences as manifestations of ADHD, including stereotypes linking ADHD solely to poor academic achievement, gender-based assumptions about how symptoms typically present, and the normalization of ADHD traits within family dynamics. For these women, cultural and social misconceptions created powerful barriers that significantly delayed their diagnosis, preventing them from accessing appropriate support and understanding their lived experiences through the lens of ADHD.

An important feature of the participants' description of their experiences living with undiagnosed ADHD was the assumption that ADHD only affected people who were struggling academically or behaviorally. Many participants were high-achieving students who excelled in school while struggling internally. Because they consistently met and even exceeded expectations, their ADHD symptoms were either overlooked or dismissed by those around them, and participants themselves often failed to recognize these symptoms as ADHD. Charity described how teachers overlooked her challenges because of her external successes and said, "If you're smart and you're reaching all of your milestones, especially educational milestones or even going above them, people don't really pay attention." Her statement reveals a pattern that many participants experienced in which their academic achievement and success became significant barriers to recognizing their ADHD symptoms. Like Charity, many other participants experienced invisibility as the trade-off for high achievement and success. Ivy shared a similar narrative from a slightly different angle, and reflected on the invisibility of her lack of study skills, and noted, "I never knew how to study. I made good grades, so no one ever stopped to care or pay attention to it." Her experience highlights the disconnect between what she was feeling internally versus how she was performing externally, a gap that may have signaled ADHD had she been observed and evaluated more closely. This invisibility was reinforced even further because of education systems that directed most of their attention to students who were visibly struggling. For example, Charity elaborated:

> For a lot of teachers, especially if it's for a class where they're dealing with a wide variety of kids, they don't really have the time to focus on me if I'm getting A's and B's in the class. It's kind of like, we can't really give a lot of attention to that.

Across participants' narratives, academic success consistently appeared as a double-edged sword where achievement both validated what they were capable of while simultaneously masking their ADHD symptoms, resulting in them not receiving the support they needed. This phenomenon became so internalized that participants even started to minimize the severity of the impact of their undiagnosed symptoms because of what they had been able to accomplish. Ivy spoke to this internal struggle:

> You've made it this far without a diagnosis, what are you talking about? So, although I don't think I was actually having these conversations out loud, I think probably subconsciously or internally, I was pushing what I was having down and saying you need to work harder.

Ivy's internal dialogue highlights how her external success seemed to invalidate her internal struggles resulting in delayed ADHD recognition. Collectively, these experiences demonstrate how cultural misconceptions about ADHD, specifically related to academic achievement, created significant barriers to participants recognizing their own experiences as manifestations of ADHD.

Beyond academic misconceptions, participants described how gender and ADHD presentation stereotypes created additional barriers to the recognition of ADHD symptoms.

Many participants expressed that a major challenge in recognizing their ADHD symptoms was that their symptoms did not align with their understanding of what ADHD looked like. Sheila noted how her perception of ADHD shaped her understanding, “Initially, I always thought ADHD was like a boy thing…so it never really occurred to me that it could be ADHD.” This gender-based perception was widespread among participants, making it difficult to connect their struggles with attention, organization, and memory to ADHD. Similarly, Bailey struggled to see her symptoms as ADHD because they did not manifest in ways that fit the stereotypical mold:

> I didn't think it was ADHD because I was like, "It's not like I'm someone who can't sit still or struggled to pay attention." My inactivity or hyperactivity was misplacing or starting things and not finishing them. I might start cooking something, and then something [else] will pop in my brain, and then I'll go do that and completely forget that I was cooking.

Similarly, Charity reflected on how her inattention presented in more quieter ways that deviated from common perceptions of ADHD:

> I didn't land on ADHD because the people that I knew who had ADHD [were] super hyper, and they can't focus. I couldn't focus, but it was not being able to focus in a different way. [My] not focusing didn't interrupt anything, like I wasn't interrupting the class. I was not focusing on what was being taught, so I would read a book or I would write poems or write a story …whereas the people that I knew who had ADHD, they couldn't focus and were talking a lot, which I never did.

Monay shared her initial dismissal of the possibility of ADHD when someone suggested she may have it because her understanding of ADHD only consisted of issues with memory, which she had learned to compensate for through excessive organizational tools. She shared, “[I] still think it’s so funny cuz I remember my ex [would] be like…"I think you have ADHD." And I'll be like, "No, I don't forget things, because I got five calendars.” These retrospective narratives highlight how ADHD symptoms can manifest in ways that differ from participants’ stereotypical perceptions of the disorder, ultimately contributing to their delayed diagnosis.

Cultural misconceptions about who can be diagnosed with ADHD created additional barriers for participants. Several participants discussed growing up in households where ADHD was either not discussed at all or was seen as a condition that only affected certain populations. For example, Bailey directly addressed this cultural misconception when discussing her family’s limited knowledge of ADHD. She said, “My parents, yes, they had heard of that [ADHD], but it was back then in the 90s known as a “White person's disorder”.” By referring to ADHD as a “White person’s disorder,” her family dismissed ADHD as a condition that Black children could have, resulting in a lack of recognition and support.

Additionally, stigma around mental health conditions within participants’ families and communities created environments where discussing or even acknowledging potential symptoms was looked down upon and sometimes punished. Monay’s experience illustrates how direct warnings and fears were used to shut down any discussion of ADHD:

> I remember my dad sat us down and was like, "If any of y'all acting like y'all got ADHD, I'm gonna give y'all a whooping." And that scared us so bad that none of us thought about that. I just immediately took that out of my head [and thought], “Well, I can't have that. I'm not allowed to.”

This warning from her father instilled fear and made her ignore and actively mask any struggles she was experiencing. Monay’s experience demonstrates how key authority figures can delay help-seeking for ADHD through threatened punishment.

For some participants, cultural misconceptions and stigma influenced participants' ADHD recognition by placing emphasis on spiritual and religious approaches over mental health services. Participants expressed how religious environments and spiritual beliefs heavily influenced how their families viewed and addressed any mental health-related concerns. For many participants, their families' responses to behavioral and attention difficulties prioritized spiritual interventions rather than clinical assessment or treatment. Prayer and seeking pastoral counsel were considered the only solutions to mental health issues rather than therapy or professional interventions. Sheila described this religious influence and expressed, "I don't even know up until this point if a lot of them [family members] believe in going to therapy. A lot of my family still [believe], you just pray. You go to church, and you pray". Charity shared similar sentiments regarding cultural perspectives. She said, "It's like, we'll just go up, and we'll pray that you feel better or, you can talk to the pastor." These reflections highlight how cultural beliefs and religious stigma created barriers and delayed participants' recognition of undiagnosed ADHD symptoms.

Subtheme: Normalcy of ADHD Traits Within Family Dynamics

A subtheme, Normalcy of ADHD Traits Within Family Dynamics, found within the theme, Overlooking ADHD Due to Cultural and Social Misconceptions, identifies a particularly nuanced barrier to the recognition of ADHD. This subtheme captures participants' reflections on growing up in family environments where ADHD traits were common and seen as normal, which ultimately delayed their recognition of ADHD. Several participants described family dynamics where shared behaviors, challenges, and coping strategies made it significantly more challenging to identify these traits as ADHD. Krystal described her family environment and shared:

> I think our family is just kind of a certain way, so, I don't think any of us ever grew up feeling like we were out of place cuz we all have these issues, and so it's just all normal.

Similarly, Tiffany reflected on how her family behaviors masked her ADHD symptoms:

> I honestly feel like my family functions a lot like me... I feel like we all are kind of dealing with the things and didn't know...So I feel like in my family space, it was hard to know that something was wrong cuz we're all kind of functioning in these…ADHD ways.

For Tiffany, it was not until she was around other people and families who did things differently that she realized the atypical nature of her family routines. She said, "Being in other spaces, it's like, oh, other people clean their house with no problem. My mom wouldn't even cook dinner sometimes until 9, 10 o'clock at night."

For Krystal, cultural explanations further normalized her family's difficulty with time management. Krystal described, "My family is Jamaican and so we're like no, this is just Caribbean time. We didn't think we didn't get to places on time, and this is just the way it is". Difficulties with time management were seen as cultural norms rather than a symptom of ADHD. These distinct accounts highlight how normalized behaviors within family dynamics represent an important barrier to being able to recognize and consider ADHD as a possible explanation for their experiences.

Theme Five: Fighting To Be Heard

"Treat me like your white patient. Give me every option. Listen to me" (Deidre)

The theme, Fighting to Be Heard, captures the difficult journey participants faced when seeking an ADHD diagnosis. Participants described navigating a healthcare system that frequently dismissed their concerns, repeatedly attributed their symptoms to other conditions, and required them to advocate persistently for a full evaluation. Participants experienced providers who minimized their experiences, which left them feeling invalidated, unheard, and misunderstood. This ongoing battle led participants to emotional exhaustion and frustration as they repeatedly had to defend the validity of their symptoms and experiences to receive an official ADHD diagnosis.

For many of the Black women in this study, the path to professional recognition and evaluation was not straightforward or easy, but rather, it was a fight. Their narratives uncovered a persistent battle against a healthcare system where they were forced to defend their experiences, navigate repeated misdiagnoses, and fight to have their symptoms acknowledged and validated. Participants described feeling as though they needed to prove their symptoms beyond a reasonable doubt in order to be believed, and still often left medical spaces feeling unheard and invalidated by healthcare providers who repeatedly dismissed ADHD as a possibility.

A common thread among participants' experiences was the persistent dismissal of their ADHD concerns, with providers often attributing their symptoms solely to anxiety or depression. This experience created a frustrating cycle where participants knew that their symptoms were not being fully addressed, but were not able to convince their providers to look beyond their initial diagnosis. Rachel described this frustrating experience:

> I wasn't trying to leave without trying to figure it out. But you know, I just was told, hey, you have anxiety….but they didn't look past the anxiety or, you know it's generally just you have anxiety and depression.

As Rachel was trying to understand her own symptoms, she encountered providers who failed to explore her symptoms further, but instead offered quick conclusions. Providers were not willing to consider alternative explanations for symptoms, leading her to feel unheard and dismissed. For Monay, this dismissal led to repeated ineffective treatments that did not address her symptoms and left her feeling worse:

> I went to my doctor and at first, they kept telling me I had severe anxiety and depression. I was like, I already know. I've been diagnosed with that since I was 17…and they kept giving me anxiety meds and everything, and it just made me feel like a zombie.

Monay's experience addresses how misdiagnosis can lead not only to ineffective interventions, but also to harmful treatments that could make symptoms worse. Despite their attempts to advocate for themselves, participants encountered resistance from providers who seemed to only consider more coexisting diagnoses instead of exploring ADHD as a possibility. These dismissive interactions impacted participants' paths to being diagnosed with ADHD and resulted in delayed recognition and treatment.

Beyond being dismissed, some participants faced overtly harmful and degrading interactions with healthcare providers that reinforced their mistrust of the medical system. As a mental health clinician herself, Ivy described a particularly painful interaction where racial stereotypes and biases affected how she was perceived and treated. Ivy shared:

> [The doctor's] nurse outright said, "What are you doing? Med seeking?" and so that hurt. She says, "Well, ADHD is not usually diagnosed in adults. So, why do you want this?" She was still on, I think, the med-seeking vibe because I'm a Black woman walking [in here] in my 30s. I think I had on sweats that day, I have locs. When you think about

> stereotypes, I'm pretty sure they just said this woman is seeking meds. She told me she would put in a referral for behavioral health. The referral never went in.

Ivy's vivid attention to detail about her appearance demonstrates her understanding of how these salient aspects of her identity intersect with stereotypes about Black women and how they impact interactions with clinicians. Ivy shared, "that hurt," revealing the emotional impact of being wrongly accused in a moment of vulnerability adding to the frustrating evaluation process. Apart from the emotional impact, the referral that was never submitted delayed access to much-needed treatment and support resulting in her having to explore other additional paths to have her concerns taken seriously. Rachel expressed a similar realization of how her appearance influenced her care. "He just didn't care to figure out what was wrong…what I looked like played a role definitely." Rachel's assured reflection highlights an unfortunate awareness of how racial biases toward Black women negatively influence treatment and care in clinical settings.

Moreover, Krystal described how the doctor's tone and approach invalidated any trust she might have had in his assessment:

> The doctor was an asshole…he was just very disrespectful, he kept cutting me off, and he told me I had ADHD, but I didn't trust him. I thought he was a quack at that point. I was like, I don't care what you have to say at this point, I just regretted even going there.

Although this provider's diagnosis was ultimately correct, his rude and dismissive behavior completely overshadowed and erased any sense of trust that Krystal had in his judgment resulting in her taking even longer to be diagnosed. This interaction highlights that the relationship and experience with a healthcare provider is just as important as the clinical knowledge of a provider.

In response to these barriers, participants had to create strategies to advocate for themselves and to increase their chances of being taken seriously by healthcare providers. Tiffany explained the detailed lengths she took to attempt to avoid not being believed by providers:

> I literally had a Word document, single-spaced, with symptoms from the top of the page to the bottom of the page cuz I'm ready. I already know your ass [is] going to question my credibility. I already know you're going to be like, well how do you know?

Tiffany’s level of preparation serves as evidence of her determination to be listened to, but also illustrates her heightened awareness of the skepticism she faced as a Black woman seeking mental health treatment. Her preemptive anticipation of having her “credibility” questioned reveals how she felt she must be overly prepared to prove her symptoms beyond a reasonable doubt in order to be believed. Despite these efforts, she and other participants still faced the risk of their symptoms and experiences being minimized or dismissed by healthcare providers.

After initial attempts to seek help were dismissed or disregarded, many participants were forced to find alternative ways to be evaluated. Monay shared how she had to find a workaround and seek an evaluation through her child’s pediatrician instead of her own doctor:

> I requested to be tested and they sent my paperwork out and then they told me [that] they also kind of put in a note to the psychiatrist that we don't think she has [ADHD] and I never got a phone call back. I think it's also like because I have a master's degree, because I've gotten this far, they just felt like, “You’re fine. You just anxious. Ain't nothing wrong”. So, I actually had to go to my daughter's pediatrician and I had to ask them, “Hey do y'all do anything to help adults?” and they were like “We do. We have somebody that helps adults get tested.”

Monay’s provider prematurely decided that she did not have ADHD without conducting a thorough evaluation because her providers did not recognize that her symptoms did not look like widely recognized manifestations of ADHD.

Collectively, these experiences highlight participants' repeated interactions with dismissive attitudes, misdiagnoses, and invalidation within the healthcare system, which ultimately delayed their ADHD diagnosis.

Theme 6: Grieving the Loss of Missed Opportunities

“I think about things. Oh, what could have happened if I had been diagnosed, you know, in my teens, or even as a kid? What more could I have done?” (Alexis)

The theme, Grieving the Loss of Missed Opportunities, captures the emotional journey that participants reported after receiving an ADHD diagnosis in adulthood. For participants, receiving an official diagnosis revealed the magnitude of what they felt they had missed while being undiagnosed throughout their lives. This retrospective reflection generated a complex grieving process as participants reflected on educational paths they did not take, careers not pursued, relationships that were negatively impacted, and years spent blaming themselves for their symptoms. Their grief was often heightened by anger toward those who failed to recognize their ADHD, particularly as they considered how race and gender contributed to them being overlooked. Even though receiving a diagnosis provided an explanation for the symptoms and struggles they had been experiencing, participants also expressed frustration after realizing that even with a diagnosis, ADHD led to ongoing difficulties without straightforward solutions. Alexis and Deidre's reflections speak to this emotional weight:

> Looking back, I understand that I was doing the best I could with what I had, but had I had a diagnosis earlier? Goodness, it could have made a huge difference in my life. I

> think about what could have happened if I had been diagnosed, you know, in my teens or even as a kid. What more could I have done? (Alexis)

Similarly, Deidre reflected, “If I had been diagnosed, how would that have impacted my life? Would it have been more positive, or would it have been more of the same?” This retrospective questioning captures the sentiments of what many participants expressed, contemplating how their lives may have been different had their ADHD been recognized and addressed sooner. For some, this grief was compounded by reflections on missed career opportunities. For example, Ivy reflected on how her diagnosis made her consider the career paths she never pursued. She expressed, “Maybe I would have gone to med school or something. That's what I wanted to do initially.” Her reflection highlights the emotional weight of the loss of missed opportunities and having to transition through life with undiagnosed ADHD and without the support she needed. For many, grief came from realizing how self-critical they had been as they blamed themselves for behaviors they now knew to be a manifestation of a neurodevelopmental condition that was beyond their control. Monay expressed grief in how harshly she judged herself before her diagnosis, unknowingly internalizing symptoms she did not realize were signs of ADHD. She reflects:

> I also went through this space of like, oh my god, I was depressed for so long thinking that I was just not succeeding and not doing what I needed to do, when really it was just my brain doing what it was programmed to do.

Similarly, Ivy expressed that she wishes she had been more compassionate to herself while she was struggling “I just wish I could give myself the grace that…I needed back then, because that would have been a lot nicer instead of [saying] “why can't you just get yourself together?””

For some participants, this grief even extended to relationships, as they recognized the ways their undiagnosed ADHD impacted and shaped their interpersonal experiences and led to misunderstandings. Tiffany regretfully described how her undiagnosed ADHD affected her friendships through what she later understood as Rejection Sensitive Dysphoria (RSD):

> Friendship-wise, I was overly sensitive in ways that I wasn't aware of. I think RSD is definitely something that have seen in my friendships. I will be ascribing an attitude to a behavior that I don't talk to people about cuz I feel like it's very clear that you don't like me. I know that there are friendships that I've lost that I perceived the situation a certain way and I did not have a conversation with them and if I had a conversation, we might have still been able to salvage the friendship.

Tiffany's experience illustrates the significant sense of grief participants experienced after understanding that emotional dysregulation and misinterpretation of social interactions associated with ADHD impacted their relationships.

Beyond grief, participants expressed feelings of anger and frustration directed toward educators, family members, medical providers, and even themselves. There was a shared sense of frustration that their symptoms had been overlooked or dismissed as laziness, a lack of discipline, or a personal failure. Several participants specifically directed their anger toward parents and other caregivers who failed to recognize their struggles. Charity shares her resentment:

> It made me kind of mad at my parents and at the adults around me for not noticing that something was... and I hate to say something was wrong, but realizing that something is different and she needs different resources than the ones that we're currently giving her.

Her reflection captures the anger and sense of loss of having her challenges and struggles consistently overlooked rather than being recognized as a need for additional support. Another participant, Krystal, shared similar feelings of resentment toward her parents for missing signs that she believes were obvious looking back:

> First, I was mad at my parents cuz I was like, "How did y'all not see that there was a problem?" And that really made me mad for a very long time. I was just like, "That's just stupid." When I think about my childhood, I'm like, "I feel like y'all should have picked up that something was wrong." And the fact that they didn't annoyed me because I felt like, okay, if they had intervened earlier maybe I could have got some help earlier, then I could have avoided a lot of stuff.

Her frustration illustrates a deep sense of grief over lost opportunities and missed potential. Her reflection highlights a shared belief amongst participants that an earlier diagnosis and earlier intervention could have contributed to receiving much needed support and avoiding unnecessary challenges. For Tiffany, her grief was directly connected to her identity as a Black girl and missed opportunities for much needed support:

> It kind of felt like, why didn't adults help me? That's the biggest question that I feel like I have sometimes. As an adult, I have the sense to be able to look back and be like, damn that was something that needed some support or some intervention. And it feels like sometimes as a Black girl, everybody's around you, all these adults are around you, and nobody is like, "How can I help?" Nobody is saying, "This person needs support. How can I be of support?"

Her reflection highlights how her deep sense of loss and grief as a result of receiving an ADHD diagnosis as an adult are impacted by her intersecting identities.

Although receiving an official diagnosis helped participants understand and reframe their challenges, it also forced them to confront the reality that ADHD was not something they could simply fix. Many described initial feelings of relief, which quickly evolved to a process of grief once they realized that this new understanding did not automatically mean solutions. Krystal shared:

> I was excited because I'm like, okay, now I know the problem, there's a solution. Once I realized it doesn't really work like that, I was mad because I just felt like I cannot control the situation. I can see how it wreaks havoc in my life, but I'm not able to be in control and it just made me angry to no end because I'm like, why out of everybody do I have to have to deal with this, I just didn't want to deal with it. And I felt like I cannot believe there's no straightforward solution to this stuff.

Her narrative reveals the grief over lost control and having to alter her expectations. Participants also mourned past perceptions of themselves as they wrestled with their newfound understanding of their limitations after being diagnosed. This internal conflict represented the psychological tension of reconciling their pre-diagnosis identity with their new understanding of themselves, leading many to question the validity of their ADHD symptoms despite the formal diagnosis. Monay expressed this internal dialogue and self-doubt. She said, "It can make me feel really frustrated with myself because I'll go through moments of, "Can you not do it or are you just acting like it?"" Krystal shared similar sentiments and grief over the way she viewed herself:

> I think sometimes I still go back and forth about it. Ignorance is truly bliss. In a way, not knowing, I never thought of there being limitations on things that I could do. So, I was just out here doing stuff, and so now that I kind of have a little bit more awareness… not that I don't have a desire to do things, but you kind of frame how you're going to

> approach things a lot differently...whereas I would have just not really cared about “Will this affect me or not?” I was just doing things, and I feel like since I've gotten diagnosed, I've done nothing. So, I was always in school or getting some type of certification, or I would have the next five years of my life planned out, and I realized ever since I've been diagnosed, I have done absolutely none of that.

Monay described an ongoing battle with “internalized ableism” that complicated her ability to accept her diagnosis. She said, “It's still like those inner ableist thoughts of just like, “That's not ADHD, that's just you.” And it's just like, I have to slow down sometimes and be like, “No babe, that's ADHD.”” These experiences illustrate a complex grieving process where participants mourned who they were before diagnosis while simultaneously processing the explanation of their symptoms that had no quick solution.

Chapter Summary

This chapter presented the findings from in-depth interviews with 10 Black women who received an ADHD diagnosis in adulthood. Six group experiential themes were identified from the data analysis, each highlighting different aspects of the participants’ lived experiences with undiagnosed ADHD. The themes identified were (1) Misattributing Undiagnosed Symptoms to Identity, (2) Navigating the Pressure to Meet Impossible Standards, (3) Developing Complex Strategies to Cope, (4) Overlooking ADHD Due to Cultural and Social Misconceptions, which included a subtheme of Normalcy of ADHD Traits Within Family Dynamics (5) Fighting to Be Heard, and (6) Grieving the Loss of Missed Opportunities. Together these themes emphasize the uniquely layered experiences of Black women who remained undiagnosed with ADHD until adulthood and highlight the internalized negative perceptions, societal pressures, coping strategies, systemic barriers, and possibilities that are available with an accurate diagnosis and earlier intervention. The next chapter will discuss these findings in more detail, explore the implications, and provide recommendations for future research.

CHAPTER FIVE

DISCUSSION

The purpose of this study was to explore the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. The findings uncovered six themes that captured these experiences: (1) Misattributing Undiagnosed Symptoms to Identity, (2) Navigating the Pressure to Meet Impossible Standards, (3) Developing Complex Strategies to Cope, (4) Overlooking ADHD Due to Cultural and Social Misconceptions (with subtheme: Normalcy of ADHD Traits Within Family Dynamics), (5) Fighting to Be Heard, and (6) Grieving the Loss of Missed Opportunities. Through an integrated theoretical framework of Intersectionality (Crenshaw, 1991) and Black Feminist Thought (Collins, 2002), this chapter discusses the significance of these findings in relation to existing literature, highlights how this study addresses critical gaps in understanding the unique experiences of Black women with ADHD, and offers implications for clinical practice, counselor education, and future research.

Interpretation of Findings

The findings of this study revealed a complex interplay between race, gender, and mental health, specifically undiagnosed ADHD, which significantly shaped how participants made meaning of their experiences. Collectively, the six themes indicate that for Black women, ADHD is not merely a diagnosis or a set of symptoms, rather, it is an experience deeply embedded within cultural, social, and systemic factors, which influenced how symptoms were perceived and addressed. The participants' narratives demonstrate how their undiagnosed ADHD symptoms were interpreted through racial and gendered lenses, creating unique challenges that extended beyond those documented in research predominately focused on White men and boys (Waite & Ramsay, 2010). The Black women in this study navigated a multidimensional experience that involved simultaneously coping with unrecognized ADHD symptoms and managing the intersecting pressures of being a Black woman and doing so without the clarity and understanding that an official diagnosis could have provided. This layered experience reflects the distinct reality of living at the intersection of being Black, being a woman, and having undiagnosed ADHD. The themes identified from this study both confirm and extend existing literature, while also offering new insights into the ways Black women make meaning of their experiences with undiagnosed ADHD. The following discussion examines how these findings connect to prior research and contribute to a more nuanced understanding of this phenomenon.

Misattributing Undiagnosed Symptoms to Identity

Black women with undiagnosed ADHD internalized their ADHD symptoms as character flaws, which fundamentally shaped their sense of self and worth. Participants experienced significant confusion about their cognitive and behavioral challenges before their ADHD diagnosis. Without an official diagnosis, both they and others around them often negatively interpreted their symptoms as personal character deficits or shortcomings, rather than manifestations of a valid neurodevelopmental condition.

This finding aligns with Young et al.'s (2008) study of adults diagnosed with ADHD later in life, which found that participants frequently attributed their undiagnosed ADHD challenges to personal failings. Like the women in this present study, Young et al.'s (2008) participants described years of misinterpreting negative feedback as reflections of their character rather than neurodevelopmental differences. Extending those findings, this present study uniquely highlights how this internalized blame is further complicated by race and gender, specifically how these misinterpretations intersected with harmful cultural stereotypes of Black women, such as aggressive, lazy, or defiant (Ashley, 2014; Lewis et al., 2016). Moreover, in line with Young et al.'s (2008) findings on the long-term psychological effects of undiagnosed ADHD, participants in this current study also expressed deep confusion about their identity when their symptoms challenged their self-concept.

Similarly, Holthe and Langvik (2017) found that women diagnosed with ADHD as adults struggled with deeply embedded feelings of lowered self-esteem, self-efficacy, and self-concept. Yet, what remained underexplored, until now, was how these internalized struggles manifested for Black women whose experiences were further shaped by cultural expectations and racial stereotypes. This present study uniquely extended previous findings about self-concept by demonstrating how the impact of undiagnosed ADHD went beyond low self-esteem and manifested as a deep sense of internalized blame and shame linked to both gender and racial norms and expectations.

Additionally, the findings of this study explicitly highlighted how racial stereotypes intensified internalized blame. For Black women who already face negative stereotypes about their intelligence and capabilities (Lewis et al., 2016; Zou & Cheryan, 2017), the misattribution of ADHD symptoms as personal flaws and failings magnifies these harmful narratives and stereotypes. For example, instead of being seen as symptoms of ADHD, participants' emotional reactions were viewed as confirming negative stereotypes about Black women. As Ashley (2014) noted, these stereotypes cause Black women's legitimate emotional responses to be misinterpreted as character flaws rather than valid reactions. As a result, Black women may be denied the opportunity for proper diagnosis and treatment, further reinforcing the pattern of self-blame and negative self-perception that our participants described.

Moreover, this study addressed a significant gap identified by Waite and Ramsay (2010) regarding the lack of research on ADHD in diverse populations, particularly Black women. By centering the voices of Black women, this research provided critical insights into how the misattribution of ADHD symptoms shaped Black women's self-concept in ways that differ from both White women and Black men (Collins 2002; Crenshaw, 1991). This impact of misattribution on identity is particularly significant when considered alongside Settles' (2006) assertion that Black women often view their identities as intertwined, affecting multiple areas of their lives and contributing to their self-perception. Therefore, counselors must be prepared to implement interventions that help Black women separate their core identity from ADHD symptoms and racial and gendered stereotypes.

Navigating the Pressure to Meet Impossible Standards

Black women with undiagnosed ADHD experienced unique challenges due to the intersection of cultural expectations and undiagnosed ADHD, which created compounded pressures that made reaching societal and cultural expectations impossible. The theme of Navigating the Pressure to Meet Impossible Standards revealed how participants' lived experiences as Black women with undiagnosed ADHD were uniquely shaped by intersecting pressures. Thus, the findings of this study confirm Chapagain's (2020) concept of "triple jeopardy," which described how Black women with mental health concerns simultaneously navigate three marginalized identities: being Black, being a woman, and having a mental health condition. The participants in this present study vividly illustrated the "triple jeopardy" phenomenon as they described how cultural pressures to be twice as good were compounded by the executive functioning challenges of undiagnosed ADHD, creating what was described as needing to be three times as good. As Crenshaw's (1991) Intersectionality theory would suggest, the participants' experiences cannot be fully understood by examining race or gender separately, but must be viewed through the lens of how these identities interact with each other and with undiagnosed ADHD to create unique challenges.

Consistent with findings related to gendered expectations in women diagnosed with ADHD as adults (Holthe & Langvik, 2017), participants in both studies expressed feeling socialized pressure to suppress hyperactive, impulsive, and disorganized behavior. For example, participants in Holthe and Langvik's (2017) study noted that due to societal expectations of femininity, they were often judged more harshly if they were unable to meet these gendered expectations. However, significantly extending this research, this present study illuminated how Black women experienced intensified judgment due to the intersection of race and gender, a critical distinction that was absent from previous studies which did not focus on racial diversity.

In addition, the emergence of a distinct intersection in this study where challenges with executive functioning directly conflicted with expectations to be organized and put together, deeply aligned with Watson and Hunter's (2015) work on the SBW schema. Specifically, Watson and Hunter (2015) found that Black women often feel pressured to embody nurturing caretaking roles (traditionally feminine), while also being completely self-reliant and strong (traditionally masculine). This conflict created an ongoing tension where Black women were expected to fulfill gendered caregiving responsibilities while being denied the benefits that typically come with them, a burden that is compounded by undiagnosed ADHD (Watson-Singleton et al.,2019).

When working with Black adult women with late diagnosed ADHD, it is important that counselors understand the cultural context in which Black women experience ADHD symptoms and incorporate culturally responsive interventions that specifically address the compounding pressures of race, gender, and undiagnosed ADHD while simultaneously addressing identity conflicts created when ADHD symptoms contradict cultural expectations.

Developing Complex Strategies to Cope

The Black women with undiagnosed ADHD in this study navigated life by using resourceful yet complex strategies shaped by their intersecting identities. Consistent with the literature, the findings indicate that adults with ADHD commonly use compensatory strategies such as organization and external support (Kysow et al., 2017; Quinn, 2005). For instance, Kysow et al. (2016) conducted a study on primarily White adult women and found that adults with ADHD developed compensatory behaviors such as using a calendar and selecting environments that matched their needs. The present study's findings confirmed these results yet also illustrated how Black women with undiagnosed ADHD used strategies that were distinctly layered in nature and intensity. Similarly, participants in this study utilized calendars and organizational methods; however, they often used multiple overlapping systems that were used simultaneously, such as five different calendars in multiple formats, and setting extensive security systems to address their unique challenges with forgetfulness and attention difficulties.

While Kysow et al. (2016) found that Adaptation strategies (i.e., modifying tasks or environments to better fit abilities) were most common, Black women in this study seemed to rely more heavily on what Kysow et al. (2016) termed Paying Attention strategies (i.e., conscious effort to control behavior through heightened awareness and putting in more effort to compensate). This difference may stem from the present study's focus on the period of being pre-diagnosed when impairing symptoms are still unexplained.

Notably, compensatory strategies among Black women in this study served the dual purpose of managing ADHD symptoms and protecting against harmful racial and gender stereotypes. In their study exploring the advantages and challenges of embodying the SBW schema, Watson and Hunter (2015) found that Black women often adapted their behaviors in order to prove themselves as equal citizens and also disprove negative perceptions and stereotypes of Black women. Building on this insight, this present study illustrates how these behavioral adaptations become even more burdensome when intersecting with undiagnosed ADHD.

While previous literature has explored how Black women utilize various strategies to navigate gendered racism (Lewis et al., 2016) and highlighted their pressured determination to succeed despite having limited resources (Woods-Giscombé, 2010), the present study explicitly revealed how these strategies become further complicated when simultaneously addressing undiagnosed ADHD symptoms. Thus, it is critical that counselors be able to recognize how excessive organization, perfectionism, or over-controlling behaviors in Black women might actually be adaptive responses to undiagnosed ADHD, which are complicated by the pressure to combat racial and gendered stereotypes. Understanding this nuanced and layered reality is critical to providing culturally responsive and accurate assessment and treatment for Black women.

Overlooking ADHD Due to Cultural and Social Misconceptions

Unlike common symptoms of ADHD, specifically related to problems in educational settings, many participants were high-achieving students whose external success masked their internal struggles. The finding that academic success masked ADHD symptoms in Black women with undiagnosed ADHD directly contradicts dominant narratives in ADHD literature which primarily associate the disorder with academic underachievement (Barkley et al., 2006; Kuriyan et al., 2012). While earlier studies documented how ADHD often leads to poor academic outcomes (Barkley et al., 2006; Kuriyan et al., 2012), participants in this current study described how their high achievement actually prevented recognition of their symptoms, creating a contradictory barrier to diagnosis. This phenomenon builds upon Quinn and Madhoo’s (2014) comprehensive review that revealed gender disparities in ADHD presentation by demonstrating how high achievement further hides symptoms that are less visible, particularly within the unique context of societal expectations placed on Black women.

Cultural narratives and social misconceptions about ADHD created powerful barriers that directly contributed to participants remaining undiagnosed until adulthood. While Waite and Ramsay (2010) acknowledged the lack of diversity in ADHD research, the findings of this study extend their review by providing concrete evidence of how cultural misconceptions created specific barriers to ADHD recognition for Black women. The present study revealed how cultural narratives, particularly the prioritization of spiritual approaches over clinical interventions, directly prevented participants from considering ADHD as an explanation for their struggles. Moreover, participants' descriptions of family dynamics, where mental health concerns were primarily addressed through religious practices, such as prayer over professional support, aligned with established patterns in the literature. For example, Woods-Giscombé's (2010) explored how Black women perceive and describe the Superwoman role. The author found that spirituality served as a primary coping strategy for Black women when overcoming challenges, particularly when formal support systems were lacking or perceived as inadequate. The current findings revealed similar patterns as Black women with undiagnosed ADHD reported family members’ recommendations for prayer and church attendance rather than clinical interventions. This cultural preference for spiritual approaches contributed to delayed ADHD recognition and treatment among participants in the current study.

The participants also revealed specific familial barriers to recognizing and addressing ADHD symptoms. Some participants described growing up in family environments where ADHD traits were normalized or attributed to cultural norms, which aligns with research indicating strong genetic heritability components of ADHD (Faraone et al., 2006). It is possible that inherited ADHD traits may contribute to family environments that normalize and perpetuate these symptoms. Consequently, identifying these behaviors as atypical becomes more complicated when multiple family members display similar difficulties in areas such as time management, organization, or forgetfulness. Notably, the normalization of ADHD-related behaviors within families remains underexplored in existing literature on Black women's experiences.

Although Quinn and Madhoo (2014) argued that ADHD symptoms in one family member should signal the need for assessment among others, especially individuals like girls who are more likely to be overlooked, findings from this present study indicate that recognition is hindered precisely because multiple family members likely have undiagnosed ADHD. These intergenerational patterns highlight the importance of counselors intentionally examining familial and cultural contexts when assessing Black women for ADHD.

Fighting to be Heard

Black women who remained undiagnosed with ADHD experienced a frustrating diagnostic process consisting of dismissal and misdiagnosis, revealing how racial and gender biases within the healthcare system served as a significant barrier to recognition and treatment. These findings strongly align with previous research while offering new insights into the specific challenges Black women face when seeking an ADHD diagnosis. For example, Nicolaidis et al. (2010) conducted a study with low-income Black women with depression and histories of violence victimization and found that participants frequently attributed negative healthcare experiences to racial bias. While both studies documented experiences of racial bias, being dismissed by providers, and having to advocate for themselves, the current study revealed ADHD-specific barriers where Black women's symptoms were frequently misattributed to anxiety or depression despite their constant self-advocacy. Although the participants had different educational backgrounds, the Black women in the current study faced similar discrimination patterns as those reported in Nicolaidis et al.'s study (2010) over a decade ago, suggesting persistent systemic issues at the intersection of race, gender, and mental health in health care settings.

The current study's participants' reflections on being dismissed by providers also validate Jones et al. (2014) and Ullman and Lorenz's (2020) research documenting Black women's deep-rooted mistrust of healthcare providers stemming from historical and ongoing experiences of discrimination. For example, in the study of 29 Black women who received mental health services, Jones et al. (2014) determined that participants had significant mistrust toward mental health providers, particularly White clinicians, and reported that these providers could not fully relate to their experiences and often ignored race-related issues in treatment. In the same way, the present study demonstrated how mistrust often manifests in ADHD diagnostic contexts, specifically in cases when Black women utilized specific preparation strategies, such as creating extensive documentation, in response to anticipated racial bias.

This study also contributed to a new understanding of how metastereotype awareness, defined as when a person is aware that other people have certain stereotypes or fixed ideas about their group (Jerald et al., 2017), creates a distinct experience for Black women throughout their diagnostic journey. Jerald et al. (2017) found that this awareness of stereotypes can lead to stress and unhealthy coping mechanisms, and findings of the current study revealed how metastereotype awareness specifically manifested in clinical settings. Several participants in the current study revealed that they were highly aware of stereotypes and anticipated that healthcare providers would view them based on fixed racial and gender ideas. Participants' extensive preparation of documentation and self-advocacy represents a unique burden to prove their symptoms to providers, a task that is not often required of other populations.

Finally, participants' experiences of racial stereotyping in clinical settings, such as being perceived as med-seeking, directly align with DeBlaere et al. (2023) findings in which Black women reported experiencing higher levels of racial microaggressions from White therapists compared to BIPOC therapists. DeBlaere et al. (2023) found that these microaggressions damaged perceptions of cultural humility and the working alliance, which are key factors in positive therapeutic outcomes. The present study extends their findings by demonstrating how microaggressions further delayed appropriate diagnosis even when providers correctly identified ADHD, as this breach of trust undermined diagnostic credibility. Therefore, counselors should work to develop cultural humility when working with Black women by acknowledging historical mistreatment in healthcare, recognizing their own potential biases, and creating safe spaces where Black women can feel heard and believed when discussing their ADHD symptoms and challenges.

It is important to note that while the majority of participants described having to fight to be heard, several women shared more positive ADHD evaluation experiences that provided valuable insights into what is effective for Black women with undiagnosed ADHD. Participants who had positive experiences described providers who conducted thorough life history assessments, showed genuine interest in their lived experiences, and demonstrated awareness of how ADHD manifests differently across diverse populations. Most importantly, these experiences were considered validating and supportive not simply because participants received an official ADHD diagnosis, but because they genuinely felt seen, heard, and understood by the provider. This finding supports Cuevas et al.'s (2016) work, demonstrating that Black women prioritize providers with specific skills who thoroughly address their concerns, regardless of the provider's racial identity.

Grieving the Loss of Missed Opportunities

Black women experienced a significant feeling of grief after receiving an ADHD diagnosis in adulthood. This grief was distinctly impacted by cultural expectations, as receiving an ADHD diagnosis challenged their identity as a Black woman who were expected to excel and exceed expectations despite challenges (Woods-Giscombé, 2010). These findings are aligned with research conducted by Watson-Singleton et al. (2015, 2019) regarding the SBW schema, which revealed how the cultural and often internalized expectation to be strong and self-reliant may have complicated participants' acceptance of their ADHD diagnosis. For the women in this study, receiving an ADHD diagnosis created tension in their self-perception, leading to feelings of grief and sadness which was directly related to their cultural identities.

These findings also aligned closely with previous research by Stenner et al. (2019), who explored identity transformation in adult women following ADHD diagnosis. In both studies, the formal ADHD diagnosis functioned as a critical "emergent event" that fundamentally reshaped participants' understanding of themselves. Both identified complex emotional responses, such as relief at finally understanding their lifelong challenges and grief, as participants retrospectively examined their past experiences through their new understanding of ADHD. Similarly, findings from this study reflect Holthe and Langvik's (2017) exploration of emotional responses following a late diagnosis of ADHD in a sample of five adult women between the ages of 32 and 50. Like the present study, Holthe and Langvik's (2017) found complex emotional reactions and ongoing emotional challenges experienced after diagnosis. In both studies, participants identified relief at finally understanding lifelong struggles, while simultaneously recognizing ongoing emotional burdens. Holthe and Langvik (2017) described a mix of emotions among participants, and the current study uniquely emphasizes the deep sense of loss that accompanied a late diagnosis, an aspect mentioned by previous authors but not thoroughly explored. Counselors could best serve Black women with a late ADHD diagnosis by approaching counseling with cultural sensitivity and creating therapeutic spaces that acknowledge both relief and grief as valid and interconnected responses to a late ADHD diagnosis.

Implications of Study Findings

The six themes identified in this study provided critical information about the experiences of Black women with undiagnosed ADHD until adulthood. By examining the intersection of race, gender, and undiagnosed ADHD through the voices of Black women, this research has important implications for efforts to close the longstanding gap in ADHD diagnosis and treatment. The following sections speak directly to the barriers Black women in this study faced while navigating undiagnosed ADHD within environments that have historically overlooked their experiences and provide actionable strategies counselors and educators can implement to reduce these barriers, improve recognition, and better support Black women with ADHD.

Implication for Counselor Educators

The findings from this study present significant implications for counselor educators and graduate training programs, which play a critical role in preparing future counselors to work effectively with diverse populations (American Counseling Association [ACA], 2014).

Specifically, the lived experiences of Black women who remained undiagnosed with ADHD until adulthood highlight several areas where counselor educators can implement new or additional content and skill-development among students to better serve this population.

First, counselor educators must integrate intersectional perspectives of ADHD into their curriculum, teaching future counselors how race, gender, and ADHD interact to create unique experiences for Black women. This modification requires moving beyond generic multicultural competence (Lekas et al., 2020), to specifically addressing how biases and stereotypes about Black women may obscure the recognition of ADHD and other neurodevelopmental or mental health conditions. Additionally, counselor education programs should address the historical and modern-day barriers Black women face in healthcare settings, thereby preparing future counselors to recognize and counteract their own biases when working with this population. Counselors must be willing to understand and respond to another person's experiences, utilizing a nonjudgmental approach while learning about the client's cultural background and experiences (Summers & Nelson, 2022).

Secondly, the finding that participants' symptoms were dismissed due to academic achievement highlights the need for more nuanced diagnostic training that captures the full spectrum of ADHD presentations beyond the commonly known stereotypical behaviors of a White male child. It is important that training programs educate counselors-in-training on the diverse presentations of ADHD, particularly how symptoms may manifest differently in women across cultural contexts. For example, it is important that future counselors are trained to recognize that ADHD may present in ways that are not overtly hyperactive, as usually reported in boys, but instead, women may experience more internal feelings of confusion and turmoil (Quinn, 2005). This internal struggle may include self-criticism, feelings of being overwhelmed, and constant frustration when trying to keep up with everyday tasks (Waite & Ivey, 2009). Thus, current assessment approaches may be insufficient for identifying ADHD in Black women who may have developed strategic compensatory strategies or whose symptoms present in ways that look different from traditional clinical descriptions. Future counselors must learn to think critically about the appropriateness of current assessment instruments among members of diverse cultural groups.

Counselor educators can strengthen their training programs by inviting Black women with lived experiences of ADHD as guest speakers in counseling courses to share their unique perspectives. The first-hand lived experiences can provide invaluable insights that textbooks and research articles alone cannot offer, which may cultivate deeper understanding and empathy among counselors in training. Additionally, counselor educators can develop case studies and vignettes featuring Black women with ADHD that demonstrate how symptoms may present differently due to cultural factors, compensatory behaviors, and societal expectations. By implementing these recommendations, counselor educators can help prepare future counselors who will be better equipped to recognize, assess, and support Black women with ADHD.

Implications for Clinical Mental Health Counselors

The findings of this study offer several important implications for practicing counselors and other mental health professionals working with Black women who may have undiagnosed ADHD or who have recently received an ADHD diagnosis in adulthood. The experiences shared by participants highlight the need for more culturally responsive approaches to assess and treat ADHD that consider the unique intersections of race and gender.

First, it is important that mental health clinicians expand their understanding of how ADHD manifests in Black women beyond the stereotypical hyperactive presentation commonly associated with ADHD so that they can share accurate information about ADHD with Black women who were diagnosed later in life. Due to the lack of awareness of the diverse manifestations of ADHD (McLeod et al., 2007; Waite, 2007) and the crucial importance of psychoeducation in ADHD treatment (Pederson et al., 2022), psychoeducation should be provided to Black women who were diagnosed with ADHD as adults to educate clients about the condition, its impact on their lives, and informing them of their treatment options (Seery et al., 2023). Clinicians should be particularly prepared to educate clients on the unique presentation of ADHD and also help clients process their deep feelings of loss as they retrospectively reflect on potential missed opportunities. To address the grief experienced by Black women following a late ADHD diagnosis, counselors must move beyond empathetic listening to provide concrete therapeutic intervention (Silas & Seward, 2023). Research by Seery et al. (2023) demonstrates that Acceptance Commitment Therapy (ACT), when combined with targeted psychoeducation, may improve how adults with ADHD understand ADHD and develop self-acceptance. This approach directly addresses executive functioning challenges, promotes self-compassion, and enhances emotional regulation, areas that have been shown to be severely impacted by late-diagnosed ADHD in women (Morgan, 2024).

Black women in this study were repeatedly dismissed, misdiagnosed, or required to persistently advocate on their own behalf to be assessed properly. In response, mental health professionals must actively work to counteract these harmful patterns by creating clinical environments where Black women feel validated from the very first interaction. Recognizing that Black women often carry justified mistrust due to previous negative healthcare experiences (Jones et al., 2014; Nicolaidis et al., 2010), mental health clinicians must engage in practices that foster trust building and provide transparency throughout the assessment process. Mental health professionals should be particularly vigilant to avoid premature attributions of symptoms to anxiety or depression without thoroughly exploring ADHD,

Mental health professionals who work with Black women with ADHD should also implement comprehensive evaluations that include screening interviews exploring the impact of ADHD across multiple life domains while remaining sensitive to how symptoms might present differently in this population. Drawing from Watson-Singleton et al.'s (2019) framework for culturally responsive interventions for Black individuals, clinicians should consider incorporating cultural values into the assessment process, use terminology and language that is culturally familiar, and provide tailored resources that resonate with Black women's experiences. The assessment process should emphasize careful differential diagnoses that avoid prematurely attributing symptoms to anxiety or depression without thoroughly exploring ADHD as a possible diagnosis. Assessment should include in-depth clinical interviews exploring the developmental history and symptom patterns, with particular attention to how academic achievement may have masked symptoms. The biopsychosocial assessment should explore how cultural expectations, the SBW schema, and experiences of gendered racism have interacted with ADHD symptoms throughout the lifespan.

The findings of this study highlight the need for advocacy efforts focused on the community that address the unique challenges Black women face in receiving timely ADHD diagnosis and appropriate support. Clinical mental health counselors should also engage in advocacy efforts that extend beyond individual therapeutic relationships and interact with broader social, educational, and cultural contexts that influence how ADHD is understood and addressed within the Black community. Utilizing principles of Community Partnered Participatory Research (CPPR) (Sankaré et al., 2015), advocacy initiatives should prioritize equitable partnerships with Black women who have lived experiences with ADHD, ensuring their voices are centered in all phases of planning and implementation. By recognizing the community as a unit of identity and building on community strengths, counselors can help co-create culturally relevant initiatives that challenge common stereotypes and misinformation held amongst the Black community. These programs should be delivered in trusted, familiar spaces such as churches, community centers, and historically Black colleges and universities, where engagement and receptivity are likely to be higher (Watson-Singleton et al., 2019). Additionally, increasing representation of Black women in ADHD educational material in healthcare settings and professional development training could help address the misconception that ADHD primarily affects White boys and men, making the condition more recognizable for Black women and their families (McLeod et al., 2007; Waite & Ramsay, 2010).

Implications for School Counselors

The findings of this study have particularly significant implications for school counselors who play a crucial role in the early identification and support of students with ADHD. The experiences of Black women who remained undiagnosed until adulthood highlight critical gaps in early recognition and intervention of ADHD, which could occur in the school setting.

School counselors could develop and implement comprehensive psychoeducational programs specifically about ADHD for classroom lessons, focusing on the diverse ways ADHD presents across genders and cultural backgrounds. These programs should explicitly address common misconceptions about ADHD only affecting hyperactive boys or academically struggling students. By providing age-appropriate information about executive functioning, attention challenges, and emotion regulation, these lessons could help students, particularly

Black girls, recognize and name their experiences rather than internalizing them as character flaws.

Additionally, because teachers are often in a position to be the first to observe patterns related to attention, distractibility, and social interactions due to their daily proximity to students in structured classroom environments (Jiang et al., 2019) and given that they are more likely to refer boys than girls for ADHD evaluations (Sciutto et al., 2004), school counselors should develop and deliver teacher training programs that help teachers recognize how ADHD may present in Black girls. These trainings should address how hyperactivity may present as internal restlessness rather than external behavioral disruptions, how academic achievement can mask significant struggles, and how behaviors often attributed to personality, such as forgetfulness and disorganization, may actually be ADHD symptoms (Sciutto et al., 2004; Waite & Ramsay, 2010). By equipping teachers with this knowledge, school counselors can help interrupt the cycle of Black girls being overlooked for ADHD assessment and support, potentially preventing the years of misattribution and self-blame described by adult Black women diagnosed with ADHD as adults (Epstein et al., 2017; Mulligan, 2001).

School counselors should also establish regular ADHD assessment opportunities within schools by coordinating with school psychologists or district mental health professionals to conduct periodic screenings, particularly for students showing subtle signs of intention rather than only hyperactivity. These assessments should incorporate culturally responsive measures that consider ADHD may present differently in Black girls (Waite & Ivey, 2009). Furthermore, school counselors can develop parent education workshops that partner with mental health care providers in the community, focused specifically on recognizing ADHD symptoms in girls, especially those from minoritized backgrounds who may be overlooked (Bussing et al., 2012).

These workshops should provide parents with concrete resources for assessment, emphasize how academic achievement can mask ADHD, and address cultural stigmas and misconceptions surrounding mental health.

Furthermore, ADHD, whether diagnosed or undiagnosed, has been shown to have significant impacts on children's self-esteem and self-worth, often accompanied by feelings of shame and internalized blame from experiencing difficulties that others do not seem to understand (Attoe & Climie, 2023). To address these concerns related to undiagnosed ADHD in Black girls, school counselors could implement weekly ongoing small groups specifically for Black girls showing signs of executive functioning challenges, difficulties with attention, or struggling with organization and time management, regardless of formal diagnosis. These small groups should include lessons around building self-esteem, self-worth, and identity development. In accordance with Park and Park (2015), these small groups may benefit from exploring self-understanding, interpersonal relationships, and positive communication, areas that directly counter the negative perceptions participants developed before their diagnosis.

School counselors should ensure that groups are led by Black women, when possible, a component of culturally responsive care that has been found essential to cultivate representation and belonging among Black people (Watson-Singleton et al., 2019). This approach creates safe spaces for Black girls to discuss their challenges without fear of confirming negative stereotypes while simultaneously teaching coping strategies that many participants wish they had learned during their developmental years (Watson-Singleton et al., 2019; Woods-Giscombé, 2010).

Beyond direct services, school counselors must also advocate for systemic changes within educational settings that better support Black girls with potential ADHD. This includes advocating for more diverse representation in school psychological evaluation teams, pushing for culturally responsive assessment tools, and challenging disciplinary policies that disproportionately impact Black girls whose ADHD symptoms may be misinterpreted as behavioral problems (Epstein et al., 2017). School counselors can partner with parent-teacher associations to raise awareness about how ADHD presents differently across gender and race, challenging harmful stereotypes that delay identification. They should also advocate for adaptations to the curriculum and classroom accommodations that support diverse learning needs without requiring a formal diagnosis (Mulligan, 2001), which could potentially benefit undiagnosed Black girls who are struggling silently with ADHD symptoms while maintaining academic achievement. By implementing comprehensive identification strategies, culturally responsive interventions, and systems advocacy, school counselors can play a pivotal role in interrupting the pattern of delayed diagnosis for Black girls with ADHD.

Recommendations for Future Research

This study provided useful insights into the experiences of Black women who were diagnosed with ADHD as an adult. However, more research is necessary to better understand how ADHD affects Black women across different contexts and life stages. The findings from this study point to several important directions for future research that could further expand this line of research.

First, future research should quantitatively examine the prevalence and patterns of ADHD diagnoses among Black women, particularly investigating the rates of early versus late diagnoses. Given that the median age of diagnosis for participants in this study was in their thirties, research is needed to determine whether this delayed diagnosis is a widespread phenomenon among Black women and, if so, to identify the factors that contribute to this delay. Additionally, studies should also evaluate which assessment tools and diagnostic approaches are most effective for identifying ADHD in Black women, considering cultural factors that may influence symptom presentation and interpretation. This research should aim to develop more culturally sensitive diagnostic methods that account for the unique experiences and presentation of ADHD in this population.

Beyond diagnosis, future researchers should explore Black women's preferences for ADHD treatment modalities, including medication, therapy, coaching, and alternative approaches. Moreover, future researchers could explore how cultural stigmas and historical mistrust of healthcare systems may influence treatment preferences and engagement among Black women with ADHD. Studies should also develop and evaluate culturally responsive interventions specifically designed to address the unique challenges Black women face at the intersection of race, gender, and ADHD. These interventions should not only target the core symptoms of ADHD, but also the psychological impacts of late diagnosis, including grief, identity reconstruction, and navigating ADHD with cultural expectations.

Furthermore, more research is needed to clarify misconceptions about ADHD within Black communities and to better understand how these cultural narratives influence recognition, help-seeking, and treatment of ADHD among Black women. Specifically, this research should explore cultural attitudes toward neurodevelopmental conditions, mental health literacy, and barriers to accessing appropriate care. In addition, researchers should also explore how domestic and household expectations interact with ADHD symptoms for Black women, as participants in this study identified this as a significantly difficult area. This domestic domain has been underrepresented in existing research, which indicates an essential area for future intervention.

Interestingly, despite previous research showing higher rates of academic difficulties and unemployment among individuals with ADHD, all participants in this study had completed college degrees, with 80% holding advanced degrees and 90% working full-time. Thus, future researchers should explore this discrepancy, investigating the factors that contribute to some Black women with ADHD achieving academic and professional success despite their undiagnosed symptoms. Finally, research is also needed on how ADHD affects self-esteem and identity development in Black women, particularly exploring how the identity reconstruction processes might differ across various racial and ethnic groups of women with ADHD. Such research could inform culturally responsive approaches to support Black women through the process of disentangling ADHD symptoms from internalized stereotypes and cultural expectations.

Limitations of the Study

While this study provides valuable insights into the experiences of Black women who remained undiagnosed with ADHD until adulthood, several limitations must be discussed. First, the recruitment strategy primarily through Facebook support groups may have limited the diversity of perspectives, potentially excluding Black women who don't use these platforms or seek support through different channels. The exclusively online nature of the study through Google Meet required participants to have reliable internet access, potentially excluding those with limited connectivity. Some participants may have also faced challenges finding private spaces to discuss sensitive topics, which have affected the depth of what they were willing to share.

Additionally, the sample was relatively homogenous in terms of educational attainment, with all participants having completed at least a bachelor's degree and 80% holding advanced degrees. Thus, the findings may not represent the experiences of Black women with ADHD who did not pursue higher education, potentially excluding those who faced more severe impacts on their academics from their undiagnosed ADHD symptoms.

The age range of participants also presents a limitation as participants were between the ages of 31- 51, meaning that the findings do not fully capture the experiences of younger Black women who grew up during a time when ADHD has become more societally recognized or older Black women who grew up in different historical climates with varying cultural attitudes toward mental health. Furthermore, all participants were diagnosed between the ages of 29 and 50, which may not reflect the experiences of Black women diagnosed earlier or later in life.

Another limitation of this study is that there was no set requirement for how long it had been since participants received their ADHD diagnosis. Participants' length of time since diagnosis ranged from recently diagnosed (0 years) to up to 11 years ago. This variation in the length of time since diagnosis leads to another important limitation related to recall bias. The retrospective nature of this study, in which participants were asked to reflect on childhood and early adult experiences, may have been influenced by their current understanding of ADHD. Although this retrospective meaning-making served a valuable part in this interpretive phenomenological approach, it may not fully capture how they understood their experiences before receiving a diagnosis.

A final limitation of this study relates to my positionality as a Black woman researcher interviewing other Black women about their experiences. While my shared racial and gender identity likely created rapport and comfort that facilitated open discussion of sensitive topics, it may have also led to certain assumptions of shared understanding. Consequently, participants might not have explicitly articulated connections between their experiences and their racial and gender identities because they assumed I would inherently understand these connections based on our shared identities and the stated focus of this study. This insider status may have resulted in some experiences being partially verbalized or specific cultural nuances being implied rather than explicitly stated, with participants assuming our shared background would automatically fill these gaps. While efforts were made to ensure trustworthiness through peer debriefing, maintaining a detailed audit trail, and conducting consistent research team meetings, this limitation highlights the complex nature of qualitative research when researchers and participants share salient identities. Additionally, the interpretive nature of IPA inevitably means that analysis is influenced by the researcher's own perspectives and experiences. As a result, different researchers might highlight different aspects of the participants' narratives or interpret them through alternative theoretical frameworks.

Chapter Summary

This study addressed a critical gap in the counseling literature by illuminating the complex intersection of race, gender, and undiagnosed ADHD through the lived experiences of Black women diagnosed with ADHD in adulthood. The findings revealed that current ADHD diagnostic practices and mental health systems are failing Black women in significant ways, often leaving them to navigate significant challenges without appropriate recognition or support until well into adulthood. By centering Black women's voices, this research challenges dominant narratives within ADHD literature that have historically excluded or marginalized their experiences.

The implications of these findings extend far beyond individual clinical practice, calling for systemic transformation across multiple domains. For counselor educators, this research highlights the need for a fundamental shift in how ADHD is taught and conceptualized, requiring a greater emphasis on intersectionality in assessment and treatment approaches. For mental health providers, these findings highlighted the urgent need to examine and address biases that contribute to dismissal and misdiagnosis while developing culturally responsive evaluation protocols that recognize the unique presentation of ADHD in Black women. Moreover, school counselors are positioned to disrupt this pattern of delayed diagnosis through earlier identification and targeted support programs that recognize ADHD in high-achieving Black girls who may be masking their symptoms.

Importantly, this research urges the counseling field to move beyond individual-level interventions and address the broader social, cultural, and structural factors contributing to delayed diagnosis. By capturing the deep grief and loss experienced by Black women following diagnosis, this study emphasizes the human cost of continued inaction and provides direction for building more equitable, culturally responsive approaches to ADHD across the lifespan. Through these insights, the counseling profession has an opportunity to lead meaningful change that amplifies the lived experiences of Black women and actively works to dismantle the systemic barriers that have historically delayed recognition, diagnosis, and care.

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Appendix A

Research Study Online Demographic Questionnaire

Thank you for your interest in this research study. My name is Lynell Williams, and I am a doctoral candidate in the Counselor Education and Supervision Program at the University of Georgia, completing my dissertation research.

The purpose of this study is to explore the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. Specifically, this research aims to understand how these women make meaning of their experiences living with undiagnosed ADHD and how the intersection of race, gender, and mental health have shaped their pre-diagnosis experiences and their path to receiving a diagnosis. Through this study, we hope to amplify the voices of Black women whose experiences with undiagnosed ADHD have been historically overlooked in both research and clinical practice.

Before enrolling in this study, we need to ask you some questions to determine if you meet the eligibility criteria. This questionnaire should take less than 15 minutes of your time. There are no anticipated risks to answering these questions.

All information received from this questionnaire, including your name and any other information that can possibly identify you, will be strictly confidential and password protected. Your participation is voluntary, and you can refuse to answer any questions or stop completing the questionnaire at any time without penalty.

If you have any questions about this research project, please feel free to email me at Lynell.williams@uga.edu. You may also contact my faculty advisor, Dr. Amanda Giordano, at amanda.giordano@uga.edu.

Questions or concerns about your rights as a research participant should be directed to the Institutional Review Board (IRB) Chairperson at 706-542-3199 or irb@uga.edu.

Thank you for your time,

Contact Information

What is your first name?

What is your last name?

What is your preferred email address?

What is the best phone number to contact you if needed?

Qualification Criteria

Please select the racial identity that best fits for you:

- Black
- Multiracial or biracial
- A race other than Black
- Other

What is your current age?

- [open-ended answer box]

Do you identify as a cisgender woman (meaning, you were assigned female at birth and identify as female currently)?

- Yes
- No

Have you been diagnosed with ADHD by a healthcare professional?

- Yes
- No

At what age were you officially diagnosed with ADHD?

- [open-ended answer box]

What healthcare provider officially diagnosed you with ADHD?

- Primary care physician (e.g., family doctor, physician assistant, medical doctor)
- Psychiatrist
- Licensed professional counselor (LPC)
- Marriage and Family Therapist (MFT)
- Psychiatric/mental health nurse practitioner
- Psychologist
- Other [text box]
- I’m not sure

Have you lived in the United States since you were at least five years old?

- Yes
- No

Other Relevant Information

What is the highest level of education you have completed?

- Some high school, no diploma
- High school graduate or equivalent (e.g., GED)
- 1–2 years of college (some college, no degree)

- 2-year college degree (Associate’s degree)
- 4-year college degree (Bachelor’s degree)
- Master’s degree (e.g., M.A., M.S., M.Ed.)
- Specialist degree (e.g., EdS)
- Doctoral or professional degree (e.g., Ph.D., Ed.D., M.D., J.D.)

What is your current work status?

- Employed full-time
- Employed part-time
- Self-employed
- Unemployed
- Student
- Retired
- Other [open ended answer box]

What is your marital status?

- Single, never married
- Married
- In a domestic partnership or civil union
- Separated
- Divorced
- Widowed
- Other

Do you currently have children living in your home?

- Yes
- No

If yes, what is your parenting role (select all that apply)

- Biological parent
- Adoptive parent
- Stepparent
- Foster parent
- Legal Guardian
- Other (Please specify)

Are you willing to participate in a 60 to 90-minute online interview as part of this study?

- Yes
- No

Thank you for your response. We will review the information provided and contact you, regarding your eligibility. We will only contact you by phone if we are unable to reach you via email.

Appendix B

Research Study Recruitment Material

Initial Email for Eligible Participants

Subject: Research Study on Black Women’s Undiagnosed ADHD

Dear [Participant Name],

Thank you for expressing interest in participating in our research study on the lived experiences of Black women who remained undiagnosed with ADHD until adulthood. Based on your responses to the demographic questionnaire, you are eligible to participate in this study.

To proceed to the next steps:

1. Please review and sign the linked informed consent form.
2. Select a time for a 60–90-minute interview using this Google Meet schedule.

If you have any questions about the study or the process, please do not hesitate to reach out.

Thank you for your time,

Lynell Williams
Email: Lynell.Williams@uga.edu
Phone: 6788622910

Follow-up Email for Participants Not Selected

Subject: Regarding Research Study on Black Women’s Adult ADHD Diagnosis

Hello,

I wanted to personally reach out and thank you for your interest in my research study about the experiences of Black women who remained undiagnosed with ADHD until adulthood. I truly appreciate you taking the time to fill out the screening questionnaire and share information about yourself.

I wanted to let you know that we are unable to include you in the current study as we have reached our target number of participants. While your experiences and perspectives are valuable, we must maintain a specific sample size to ensure the validity of our research findings.

Since you've shown interest in this topic, I wanted to share a resource that might be helpful on your journey. I created a free information Masterclass called "The Perfectionistic ADHDer" that specifically addresses ADHD in Black women and its intersection with perfectionism.

Here's the link: [Masterclass Link]

Thank you again for being willing to contribute to this research. Your interest reinforces just how important it is to study and understand the experiences of Black women with ADHD.

With gratitude,

Lynell Williams

The University of Georgia

Lynell.Willams@uga.edu

Appendix C

University of Georgia
Participant Informed Consent

The Lived Experiences of Black Women with Undiagnosed ADHD: An Interpretative Phenomenological Analysis

Thank you for your interest in this research study exploring the effects of undiagnosed Attention-Deficit/Hyperactivity Disorder (ADHD) on Black women who received a diagnosis in adulthood. This study aims to understand how living with undiagnosed ADHD shaped Black women's lives before receiving their diagnosis, paying particular attention to how these women make meaning of their experiences living with undiagnosed ADHD and how the intersection of race, gender, and mental health have shaped their pre-diagnosis experiences and their path to receiving a diagnosis. We hope to amplify the voices of Black women whose experiences with undiagnosed ADHD have been historically overlooked in both research and clinical practice.

You are being invited to participate in this study because you are a Black woman who was diagnosed with ADHD as an adult. You are eligible to participate in this research study if you: (a) identify solely as Black, (b) are a cisgender woman, (c) are 25 years or older, (d) were diagnosed with ADHD at age 18 or older by a healthcare professional, and (e) have lived in the United States since at least age 5. If you wish to participate, you will be asked to complete one 60–90-minute interview via Zoom. Participants will receive a $10 Visa eGift card that will be emailed to the email address you provide to the researcher. Your email will be shared via the online Visa gift card checkout to receive the eGift card.

Participation in this study is voluntary. You can refuse to take part or stop at any time without penalty. You may decline to answer any question you do not wish to answer for any reason. If you choose to participate in this study, your participation could contribute to new knowledge for counselors, mental health providers, and healthcare professionals who work with Black women with ADHD. This knowledge may help improve diagnosis and treatment approaches for Black women who may be experiencing undiagnosed ADHD symptoms.

To protect your privacy, you will be asked to choose a pseudonym that will be used throughout the study. The interview will be conducted via Zoom and will be audio and video recorded for transcription purposes. All recordings and transcripts will be stored securely on a password-protected computer and encrypted external drive. Only the research team will have access to the recordings and transcripts. Any identifying information will be removed from the transcripts and final publication. While every reasonable effort will be made to keep your information confidential, absolute confidentiality cannot be guaranteed for information shared over the internet.

If you have any questions about this research project, please feel free to email me at Lynell.williams@uga.edu. You may also contact my faculty advisor, Dr. Amanda Giordano, at amanda.giordano@uga.edu.

Any questions or concerns about your rights as a research participant should be directed to The Chairperson, University of Georgia Institutional Review Board; 706-542-3199; irb@uga.edu.

Sincerely,
Lynell Williams

If you agree to participate in this research study, please sign below:

Name of Researcher	Signature	Date
Name of Participant	Signature	Date

Please keep this letter for your records.

Appendix D

Semi-Structured Interview Guide

1. Can you tell me about your experience of living with undiagnosed ADHD before receiving your diagnosis as an adult?
    a. What was daily life like for you during this time?
    b. What sense did you make of these experiences at that time?
2. Looking back at your life before receiving an ADHD diagnosis, how did undiagnosed ADHD impact various areas of your life?
    a. Can you share specific examples from your education/academic experiences?
    b. Any examples from your work life?
    c. How did it affect your relationships with others?
3. As a Black woman, how do you feel your race and gender influenced your experience of living with undiagnosed ADHD?
    a. Can you describe any specific instances?
    b. Describe how any societal expectations of Black women impacted how you understood or dealt with your struggles.
4. Before your diagnosis, how did you manage the challenges you were experiencing?
    a. What strategies did you develop to cope?
    b. Where did you seek support?
    c. How did people respond when/if you shared your struggles?
5. Can you walk me through your journey of discovering you might have ADHD?
    a. What led you to discover ADHD as a possibility?
    b. What was your experience like seeking an evaluation or treatment?

    c. How did being a Black woman impact this process?

6. What was your experience like with healthcare providers during your diagnosis process?
    a. How did clinicians respond to your concerns?
    b. Did you feel that your experiences as a Black woman were understood?
    c. What challenges did you face in accessing evaluation or treatment?
7. How has receiving an official ADHD diagnosis changed how you understand your earlier life experience?
    a. What realizations have you had about past experiences?
    b. How has this affected how you view yourself?
    c. What emotions came up for you during the diagnostic process?
8. Based on your experience of being a Black woman living with undiagnosed ADHD, what do you think is important for others to understand?
    a. What would you like mental health care providers to know?
    b. What would you tell other Black women who may be having similar experiences?
9. What support or resources do you wish would have been available to you?
10. Is there anything else about your experience of being a Black woman living with undiagnosed ADHD that you would like to share that we have not discussed?