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REVIEW ARTICLE

"Even When They Knew": Attention-Deficit/Hyperactivity Disorder Diagnosis and Post-Diagnostic Service Gaps Among Women Mental Health Professionals in Chennai

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Abstract

Adult attention-deficit/hyperactivity disorder (ADHD) in women remains underdiagnosed and insufficiently supported globally, with particularly limited research from the South Asian urban context. Women working in mental health professions may be assumed to navigate the service system with relative ease; however, the structural and gender barriers shaping care access may persist regardless of their professional knowledge. This study explores how women working as mental health professionals in Chennai experience ADHD diagnosis and post-diagnostic care access, and what barriers they encounter within systems they are professionally embedded in. Six semi-structured interviews were conducted with women aged 22–28, all working as therapists or trainee mental health professional or mental health professionals in Chennai and all holding a formal ADHD diagnosis. Data were analyzed using Interpretative Phenomenological Analysis, with Andersen's Behavioral Model of Health Service Use and a feminist mental health framework providing dual theoretical grounding. Five superordinate themes were identified: (1) The contingency of diagnosis in the absence of proactive clinical pathways; (2) the paradox of professional knowledge and persistent access barriers; (3) structural fragmentation of post-diagnostic care; (4) self-constructed support systems built in the absence of formal provision; and (5) gendered expectations as a compounding dimension of ADHD experience. Even women with professional fluency in mental health systems encountered significant barriers to ADHD diagnosis and post-diagnostic care. Barriers were structural and gendered rather than knowledge-based, with significant implications for service design, clinical training, and ADHD care policy in India.

Key words: Attention-deficit/hyperactivity disorder, adult women, Andersen's model, Chennai, feminist mental health, India, interpretative phenomenological analysis, mental health professionals, post-diagnostic care, service access

INTRODUCTION

The problem of ADHD in adult women

Attention-deficit/hyperactivity disorder (ADHD) has long been framed as a condition of childhood, and more particularly, of boyhood. Decades of research, diagnostic criteria development, and clinical training have been shaped by male-normed presentations characterized by overt hyperactivity, impulsivity, and visible disruptive behavior.[1] The consequence has been a systematic underrecognition of ADHD in women and girls, whose presentation more commonly involves inattention, internalized distress, compensatory masking, and comorbid anxiety or depression.[2,3] Women are diagnosed later, referred less readily, and receive fewer evidence-based interventions once diagnosed.[4]

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This diagnostic and care gap reflects a broader pattern in which female experiences of neurodevelopmental conditions are measured against a standard built from male data, a dynamic well-documented in feminist mental health scholarship.[5] The consequences are significant: years of unexplained academic struggle, professional difficulties, and emotional dysregulation before diagnosis, followed by inadequate access to the psychological care needed to understand and manage the condition after diagnosis.[6]

The Indian and Chennai context

Within the global literature on ADHD in adult women, research from the South Asian context is strikingly scarce. India presents a distinct set of conditions: a mental health system characterized by severe workforce shortage, widespread sociocultural stigma surrounding mental health diagnosis, and deeply embedded gendered expectations that shape whether and how women seek professional care.[7] The country has approximately 0.3 psychiatrists/100,000 populations,[8] and mental health services are heavily concentrated in urban centers, with significant variations in quality and specialist availability even within the cities.[9]

Chennai, as a major metropolitan center, represents the urban end of this landscape: a setting with greater availability of private mental health services than rural India, but one in which the services remain costly, unevenly distributed, and variable in their familiarity with adult ADHD presentations. Despite this, there is almost no published qualitative research exploring ADHD care access among women in this city or more broadly in urban South India.

The Paradox of professional knowledge

The sample at the center of this paper presents a theoretically significant case. All six participants are mental health professionals or advanced trainee therapists, psychologists, and postgraduate psychology students working within the systems they are also attempting to access as patients.[10] This professional position might be expected to confer advantage: Knowledge of diagnostic criteria, familiarity with referral pathways, and the ability to advocate for one's own needs. As the findings demonstrate, this knowledge did not protect these women from the same barriers encountered by lay service users. If those who know the system from the inside still encounter dismissal and fragmented care, the barriers are not primarily informational; they are structural and gendered.

Theoretical frameworks

This study is grounded in two complementary theoretical frameworks. Andersen's Behavioral Model of Health Service Use provides a structural account of the factors that shape healthcare access, distinguishing between predisposing characteristics (including prior health beliefs and cultural norms), enabling resources (including income, geography, and service availability), and perceived and evaluated needs.[11,12] This model has been productively applied to mental health service access research and offers a systematic lens for mapping the specific points at which care breaks down for participants.

This structural lens is held alongside a feminist mental health framework to attend to the ways gender shapes what care was offered, withheld, or distorted,[5,13] allowing the study to move between systemic conditions and the gendered dynamics of clinical encounters.

Aims and research questions

This paper reports findings from a qualitative study using Interpretative Phenomenological Analysis (IPA) to examine the lived experience of six women mental health professionals and advanced trainees with ADHD in Chennai.[14] The primary research question is: How do women working in mental health professions experience ADHD diagnosis and the post-diagnostic service gap in Chennai? A secondary question addresses the gendered and sociocultural barriers these women report encountering along these pathways. The paper proceeds as follows: Section 2 describes the methods; Section 3 presents the thematic findings; Section 4 discusses these in relation to existing literature and the two theoretical frameworks; Section 5 addresses implications; and Section 6 concludes.

METHODS

Design

This study adopts a fully qualitative design using IPA as both methodology and analytical framework. IPA is oriented toward understanding how individuals make sense of significant personal experience, and is well-suited to research exploring the lived dimensions of health and illness.[15] Its commitment to depth over breadth and to idiographic meaning-making aligns with the aims of this paper. The epistemological position was interpretive and constructivist.

Participants

Six participants were recruited for this study. All were women aged 22–28, living in or originating from Chennai, and working as therapists or mental health professionals, or undertaking advanced postgraduate training in psychology, at the time of interviews. All hold a formal ADHD diagnosis. Table 1 provides an anonymized summary of participant characteristics.

Participants were recruited through purposive and snowball sampling, initiated via social media calls. Inclusion criteria for

Table 1: Anonymized applicant features

Participant	Age	Role	Diagnosis age	Medication status	Household
P1	25	Consulting psychologist	24	Currently medicated	Lives independently
P2	27	Psychologist/entrepreneur	~7–8 (childhood)	Not medicated at interview	Lives with family; married
P3	23	Psychologist/HR practitioner	12	Not currently medicated	Lives with family; single
P4	28	Therapist/research editor	25–26	Discontinued (cardiac); seeking alternative	Lives with family; married
P5	23	Counseling psychologist	22	Discontinued (adverse reaction)	Lives with family; single
P6	22	Postgraduate psychology trainee	20	Discontinued (undisclosed side effects)	Lives independently; single

the broader PhD study required: Female gender, age 18–35, residence in Chennai, and a self-reported formal ADHD diagnosis confirmed by a qualified clinician. Diagnoses were established through participants' own accounts rather than through inspection of medical records. This focused paper draws on the subset of six participants aged 22–28, all of whom held formal diagnoses. Self-reported or suspected ADHD without clinical confirmation was not accepted as a basis for inclusion in any part of the study. All participants held or were completing postgraduate qualifications in psychology and were employed in professional roles or in advanced training at the time of interviews.

Data collection

Semi-structured one-to-one interviews were conducted online via video call, lasting 60–75 min each. Most participants chose not to enable their camera, a preference that was respected without question and is consistent with ethical practice in qualitative mental health research. Audio recordings were made with full participant consent. An interview guide developed specifically for this study covered five domains: Background and diagnostic journey; post-diagnostic care experiences; gendered experiences and clinical assumptions; coping and self-management; and a reflective closing. The guide was designed to facilitate open, participant-led accounts while providing structural anchors aligned with the study's theoretical frameworks. Interviews were conducted in English, with Tamil offered as an alternative. All recordings were fully transcribed and anonymized prior to analysis.

Ethical considerations

Ethical approval was obtained from Bharath University, Chennai. Informed written consent was obtained from all participants prior to the interview. Transcripts were fully anonymized, with all identifying details removed. A distress protocol was active during all interviews, and post-interview mental health support resources were provided to all participants. Data were stored securely with password protection throughout.

Analytical approach

Data were analyzed using IPA's iterative process of close reading, initial coding, pattern identification across transcripts, and theme development, guided throughout by the double hermeneutic: the researcher's interpretation of the participant's own meaning-making.[15] Analysis proceeded idiographically, beginning with deep engagement with each individual transcript before moving to cross-case pattern identification. Initial coding was supported by AI-assisted tools; all thematic decisions and interpretive judgments were made by the researcher, consistent with IPA principles. Participants are referred to as P1 through P6 throughout.

Researcher positionality and the peer dynamic

IPA foregrounds reflexivity as a methodological requirement rather than an optional supplement, and this study's specific configuration made reflexive practice both particularly important and particularly complex. The researcher is a PhD candidate working in the field of mental health, conducting interviews with women who are also mental health professionals and who also hold ADHD diagnoses. This convergence of position researcher and researched sharing professional training, occupational identity, and neurodevelopmental profile creates a relational dynamic in interviews that differs meaningfully from the more conventional researcher–participant asymmetry in qualitative health research.

One of the most analytically significant features of this dynamic was the participants' use of clinical and psychological language to narrate their own lived experiences. Participants draw fluently on frameworks such as executive dysfunction, masking, rejection-sensitive dysphoria, and hyperarousal to describe what was, in experiential terms, their own distress, confusion, and unmet needs. This creates an interpretive challenge characteristic of peer research: the shared professional vocabulary could produce the appearance of mutual understanding where the underlying experience remains under-explored. A participant describing her pre-diagnosis difficulties

as "classic ADHD presentation" was, in one register, communicating efficiently; in another, she may protect herself from the more vulnerable, pre-conceptual account that IPA's double hermeneutic is designed to access.

The researcher navigates this through two deliberate strategies. First, clinical terminology used by participants was consistently treated as a starting point rather than an end point, followed by experiential probes that invite participants to move beneath the diagnostic frame: "What did that feel like before you had a name for it?" or "Can you take me back to that moment?" This approach, consistent with IPA interviewing practice,[15] seeks to access the phenomenological texture of experience that clinical vocabulary, for all its precision, can foreclose. Second, the researcher maintained a reflective journal throughout data collection and analysis, in which the specific challenge of shared professional language moments where clinical shorthand risks substituting for lived accounts were systematically documented and interrogated.

The peer activity also shaped what contestants were eager to say and how. Shared professional identity appeared to lower certain barriers: participants disclosed clinical experiences including encounters with dismissive or uninformed professionals with a candor that may have been facilitated by the assumption of shared understanding. At the same time, professional identity may have introduced its own forms of presentation management. Participants accustomed to holding a competent, knowledgeable professional role in relation to their own clients may have found it harder to occupy the more vulnerable position of patient describing unmet need, and the researcher's shared professional status may have inadvertently reinforced this. This possibility was held throughout analysis as an interpretive caution: that accounts shaped by professional identity may underrepresent the full experiential weight of the difficulties described.

A specific reflexive matter concerns the recruitment of one participant. For this participant, the possibility of ADHD had first been raised, prior to and self-reliantly of this study, in an informal workplace conversation in which the researcher had been a participant. That earlier exchange formed part of the participant's own account of her pathway to diagnosis, and she referred to it directly during the interview. This prior relationship was acknowledged openly and carried two implications that were actively managed during analysis. First, it means that the researcher was, in a limited sense, part of the participant's diagnostic narrative rather than a wholly external observer of it; the account of that conversation was therefore treated with particular interpretive care, attending to the participant's own meaning-making rather than to the researcher's recollections. Second, the existing rapport may have facilitated disclosure while also creating expectations about shared understanding; as with the other participants, experiential probing was used to move beneath assumed common ground. The participant's data were analyzed using the same procedures applied across the sample, and her account converged with the others on the study's central themes rather than standing apart from them.

Finally, the researcher's professional investment in the subject matter carried both resource and risk. As a resource, it enabled contextual sensitivity and credibility with participants. As a risk, it carried potential for confirmatory reading. The reflective journal and systematic return to raw transcripts at each analytical stage served as checks against this, consistent with IPA's commitment to the double hermeneutic as an active, self-interrogating process.

RESULTS

IPA analysis generated five superordinate themes, each comprising subordinate themes. These are presented below with illustrative material drawn from participant accounts. All extracts have been lightly edited for readability while preserving meaning.

Theme 1: "No one was looking for it" the contingency of diagnosis

Across all six accounts, formal diagnoses were not the outcome of a proactive clinical pathway. Instead, every participant reached diagnosis through an external, often incidental trigger: a second therapist who happened to suggest an assessment, a sibling's diagnosis abroad, a spouse's diagnosis prompting self-reflection, a childhood referral made through a dyslexia center rather than an ADHD-specific route, or a chance conversation that first raised the possibility. No participant described being identified through systematic adult screening, and none was referred proactively by a professional on the basis of presenting symptoms alone.

P1 reached assessment only at her second attempt at therapy. Her first therapist did not raise the possibility of ADHD; her second did. The difference was, by her account, entirely a matter of chance: I was presenting my things with the therapist. And in the second session, [my] therapist told me, okay, there are a lot of things here, but I would suggest you to go for ADHD assessment… He gave me a push, so I went for it.

P4's route to diagnosis was catalyzed not by her own help-seeking but by her husband's diagnosis. As a trained psychologist herself, she had encountered ADHD in her education but had consistently externalized it; she described an orientation in which ADHD belonged to "other people": My then boyfriend, now husband, he was very sure… [a]fter we completed our post-graduation, he got diagnosed. So

after that point, he told me, you know what? I think you also have ADHD… In the workforce, the pressures were way too much for me to handle without help. So that's when I first… approached the psychiatrist.

P5 was similarly prompted by a sibling's prior diagnosis and described a delay of 2–3 years before pursuing assessment, attributed in part to family encouragement to manage without formal diagnosis.

Masking as diagnostic barrier

A consistent feature of these accounts was the degree to which effective masking and the development of compensatory strategies that concealed symptoms from external observers had actively impeded diagnosis. P5 labeled concealing so efficaciously that even her own analyst, who was well-read on adult ADHD, initially did not identify it: "I had mask my ADHD so well that even she were not able to identify the need for the diagnosis. So she were like, oh, I don't think you has ADHD. That were how well I masked it for myself… I remember even ask [the assessor], am I supposed to answer this as pre coping mechanism or post coping-mechanism, and it was only then that he realize I'd internalized it so much."

P2 noted that as an adult she would likely not meet diagnostic criteria on standard questionnaires precisely because of the compensatory systems she had developed, meaning her childhood diagnosis made before those strategies were entrenched had captured something that adult tools might now miss.

The gendered redirection

When participants did seek assessment, several described being redirected toward alternative explanatory frameworks, most commonly anxiety, stress, or personality, before ADHD was considered. P1 reported that multiple professionals had tried to reframe her concerns: They were trying to sell me therapy sessions, and they were trying to tell me that this might not be it… They were trying to tell me it was anxiety, it was trauma, or something else… I finally was] ready to take support for what I'm lacking after all these years. Again, you are pushing me somewhere [else].

P4's psychiatrist, once she did reach a diagnosis, avoided the term ADHD entirely, referring instead to "executive function issues." This linguistic evasion attributed by P4 to concerns about the term's popularization had the effect of distancing her diagnosis from a recognized clinical category and, she felt, from the community of people whose experiences might have been validating: He wouldn't even use the word ADHD. He just said executive function. And he told me specifically that just because of how this term has… started to become popular in present day use, I completely stopped using it in my practice. Even if someone has ADHD, I don't even tell them they have ADHD.

P5 reflected that her years of attributing difficulties to anxiety were not simply a personal error but a pattern reinforced by the clinical encounters she had experienced before assessment.

Theme 2: "Knowing the system did not mean I could use it" professional knowledge and persistent barrier

A central and theoretically significant finding of this study was that professional training in psychology and mental health did not translate into meaningful advantage in accessing ADHD care. All six participants possessed, to varying degrees, conceptual knowledge of ADHD, familiarity with the clinical landscape, and an understanding of how referral systems work. None of this knowledge removed the structural barriers they encountered.

P3, a postgraduate-trained psychologist, described wanting to seek re-diagnosis to understand her current status but being unable to access it due to cost: I still do want to get re-diagnosed because I like to know where I stand… [b]ut what is stopping me is the price range. As a professional, I understand why it is priced at that. But then as [a] middle class girl who just graduated, I don't think I can afford to pay that.

P4 illustrated how professional knowledge could coexist with a profound failure to recognize the condition in oneself, having for years applied to herself standards she would never have imposed on a client: I essentially treated myself as if I didn't have ADHD. So everything that worked for any person should work for me… My thinking was, ADHD/ADD people are the other and I am part of the normal.

The burden of self-advocacy and patient-led education

Several participants described moments in which they had found themselves educating clinicians about their own condition, a burden of knowledge labor that was experienced as exhausting and, at times, destabilizing. P2 described having to explain to family members, following her childhood diagnosis, that ADHD is a lifelong condition and does not resolve when medication is discontinued, a piece of clinical knowledge that her treating team had failed to communicate: The doctor said stop medications, it's done. So I thought ADHD went away… [B]ut that's not how ADHD works; you can mask it, you can cope with it, but it's… A neuropathway, and there's so much more to it. It's not like you get hurt and then you cover it up and then you're like, it's fine. Which is what many people in my family don't understand.

P4 encountered a psychiatrist who refused to accept a clinical psychology diagnostic report as a basis for prescription: I asked him if he needed me to go get assessed by [a] clinical psychologist and come back with a diagnostic report… He told me, no, I don't ever take that. Even if you come with that statement, I won't even look at it.

For P6, the burden of educating others was directed not at clinicians but at senior figures within her own academic discipline. She described having to explain her condition to psychology professors holding doctoral qualifications the very people positioned, by training, to understand it better and finding them among the less receptive: It was more of people who have higher degrees in psychology, like professors… professors with [a] PhD in counseling psychology who would say, hey, it's all in your mind. Who is giving you all this diagnosis? Don't trust all this. And I'm like, would you react the same way if someone gave you a report that said you have cancer?

The same patterns extend to her research supervision. When she disclosed that her ADHD made it genuinely difficult to engage with a research topic in which she had no interest, her response was met not with accommodation but with a flat denial that the difficulty was real a refusal, in her account, to accept ADHD as a legitimate constraint rather than a matter of will. That this dismissal came from within psychology itself, from those with the most formal knowledge of the condition, sharpens the paper's central paradox: proximity to professional knowledge did not guarantee its sympathetic application, even among those institutionally charged with holding it.

Navigating a dual identity

Participants also describe the complexity of holding a professional identity alongside a patient identity, particularly in contexts where their diagnosis was known to colleagues. P4 made deliberate and strategic decisions about disclosure, sharing her diagnosis with students in a psychology program whom she judged would be understanding, while withholding it from older colleagues whose responses she anticipated would be unsupportive. P5 notes that her awareness of the clinical literature on ADHD contributed to an initial reluctance to seek medication; she wanted to preserve what she understood as the creative and attentional quality associated with her neurodivergent profiles: I did not want… my neurodivergence be totally regulated. I wanted the creativity that came with being neurodivergent. I required it only for days when I really could not get a grip on my ADHD. But that felt kind of ignored.

This dual positioning – as professionally up-to-date patients and patient-informed professionals – represents a dimension of the insider–outsider dynamic that is not captured by typical access models, and is returned to in the Discussion.

Theme 3: "There was no next step" – structural fragmentation of post-diagnostic care

Following diagnosis, participants consistently describe an absence of coordinated onward care. Diagnosis, where it occurred, was not accompanied by a clear referral pathway, a treatment plan, or signposting toward appropriate psychological support. Participants use their own resources, professional contacts, internet searches, and peer recommendations to piece together what formal systems did not provide.

P1 describes the geographic burden of accessing care following her diagnosis in detail. Her assessment has required weekly travel to one part of the city; her psychiatric follow-up requires travel to a different location entirely; and medication refills could not be obtained locally, requiring a separate journey each time: I was not able to find someone who is next to me, who works with adult ADHD… [S]o I have to travel… and get my meds for whenever I have to go and get it. That is also just rootless itself… [E]very time I have to go there when I am taking medicine… I have to pay for my counselor, I have to pay for the second consultation, and plus my meds and all these things. It's chaos.

For participants without autonomous income or transport, these barriers were compounding rather than merely inconvenient.

The medication obstacle course

Medication access emerges as a particular site of structural difficulty. Of the six participants, only one was currently and continuously medicated; the remaining five had either never been medicated, had discontinued medication due to adverse effects, inadequate clinical communication, or parental gatekeeping, or were in the process of seeking a new prescription following discontinuations.

P5 described a panic attack the day after beginning Concert at an 18 mg dose, which she had not been adequately prepared for, and a subsequent interaction with her psychiatrist that she experienced as rigid and dismissive of her concern:

The Gendered Redirection

He say it was supposed to work 2 weeks later and I find myself having a panic attack the next day when I started taking the medication. So I was like, this is not for me… [I]t just feel like a psychiatrist mismatch for me. [H]e was not really willing to bend his ways and I were not willing to bend my ways.

That single negative experience has shaped her ongoing reluctance to retry medication, demonstrating how the quality of a single clinical interaction can have a lasting effect on treatment engagement. P4 had been prescribed methylphenidate but discontinued it following a cardiac side effect, and was navigating the process of seeking a sustained-release alternative, which she described as logistically effortful without clear clinical support.

P3's medication history illustrates a different dimension of the problem: parental gatekeeping within the clinical context. Her mother had discontinued her childhood medication due to concerns about habit formation, a common and well-documented misconception, and this decision was made without clinical challenge or follow-up. P3 now wants to

revisit her diagnostic status as an adult but faces the financial barrier of the costs of reassessment.

P6's account introduces a further and distinct dimension of medication-related harm: a failure of informed consent. Prescribed olanzapine, an atypical antipsychotic used off-label for sleep and restlessness, she was asked to attend weekly weight monitoring but was given no explanation for it. Weight gain and metabolic changes are well-established side effects of olanzapine; the failure to disclose this prior to prescription was therefore not an oversight about an unpredictable outcome but an omission of known, foreseeable risks. Only when she raised her worsening distress compounded by pre-existing body image difficulty was the connection between the medication and her physical symptoms disclosed to her: "Weekly they make me check my weight, and they never tell me why. By week 4, I say, listen, my situation were getting worse… and she go, oh yeah, that could happen because of this particular tablet's… That moment I feel betrayed by my therapist, by the person who were taking care of me."

For P6, this experience produced lasting physical consequences she attributed to the medication, and a rupture of trust that led her to discontinue care with that provider entirely and to undertake what she described as an extended search for an ADHD-informed professional she could trust. Her account adds a dimension that the other participants' medication experiences do not capture: Harm arising not from the medication's pharmacological properties alone, but from the clinician's failure to communicate, monitor transparently, and obtain meaningful informed consent. Where P5's difficulty was clinical rigidity and P4's was a physiological side effect, P6's was a breakdown of the basic communicative obligations of care a failure that, like the others, she was left to identify and act upon largely on her own.

Set against these accounts of disrupted, contested, or absent medication access, P1's description of her first effective dose stands out as the single account of pharmacological treatment working as it should. The intensity of her response speaks to the depth of needs that had remained unmet in the years before diagnosis: "When I take my med's for the first time, I started crying. The moment it kick in, I just started crying because I never feel that peace in my head. It were always 20+ tabs running in my head."

The metaphor of multiple browser tabs running simultaneously, drawn from everyday digital experience, conveys a phenomenological account of pre-medication cognitive load that no clinical descriptions had given her. That this experience was available to one participant and absent for five others is itself a finding about the distributions of effective care within this sample.

Quality inequality in private care

A consistent thread across accounts was the relationship between financial resources and the quality of care available. P4, who had encountered a therapist who promoted pseudoscientific interventions and framed her ADHD diagnosis as a "crutch," reflected that this experience was partly a consequence of financial constraint: "There are a financial constraint… [D]ifferent therapists charges at different rates. I know a person who charge about 5 K per session, and that are simply not something that I can afford. So I can offer close to one fourth of that… [W]hat if I spends 10 sessions worth of good money on a therapist? And then I find that I'm not able to establish the rapport… or they don't really understands ADHD well."

This dynamic, in which the most knowledgeable, ADHD-informed clinicians were concentrated in the most expensive tier of private practice, operated as a secondary access barrier that was invisible within standard service maps but materially significant in participants' accounts.

Theme 4: "I built it myself" self-constructed support in the absence of formal care

In the absence of tolerable formal provision, all six participants have constructed their own support systems, combinations of digital tools, relational strategies, peer networks, and informal accommodations that they had developed independently and iteratively. These systems were often sophisticated and demonstrated considerable self-knowledge; they were also the product of necessity rather than choice.

P1 had developed a multi-layered toolkit: A task management application, a visual whiteboard for reminders, multiple alarms for time-sensitive tasks, and regular body doubling sessions with friends via video call. She had also found a peer support group for neurodivergent women, which she identified as among the most valuable sources of support available to her. P2 described running her daily functioning "on anxiety" – having harnessed anxiety as an internal substitute for executive function through the use of multiple checklists and alarms – while also relying heavily on body doubling for task completion. Notably, P5 had independently arrived at the strategy of body doubling without knowing the term for it: Even before I got diagnosed with ADHD, I had kind of identified the concept of body doubling. I didn't know it as a proper concept at the time.

This independent discovery speaks to the gap between strategies known to ADHD-informed clinicians and those made available to women seeking care in Chennai.

Relational support as primary care

Across accounts, relational support – from a spouse, a sister, a close friend, or a peer network was consistently identified as more sustaining than formal provision. P2 describes her husband, who also has ADHD, as the first person who had ever matched her energy and accepted her fully, and as a daily anchor in her self-management. P5's sister, who had

been diagnosed before her and who continued to support her in processing the diagnosis, was identified as her primary resource for acceptance work. P4 described a close friend who was a psychology graduate and who managed the practical dimensions of her care when she were overwhelmed, contacting her husband, helping her remember appointments in a way that no formal professional had offered.

The centrality of relational support is consistent with ADHD literature on social scaffolding,[16] but its operation here as a substitute for rather than a supplement to formal care was clinically significant.

The emotional labor of self-management

Participants' accounts make clear that building and maintaining these self-constructed systems carried a significant burden of emotional labor. P2's description of "running on anxiety using stress as a functional driver" were particularly illustrative: "The system work, but at a cost". P3 describes the ongoing effort of managing symptom expression without formal support. P4 notes that her busier schedule paradoxically helped with focus, an accommodation she had arrived at through trial and error, not through some professional guidance.

Theme 5: "Women just have to manage" gender, expectation, and the invisible load

Gender emerges as a structurally significant dimension of how ADHD was experienced, presented, and responded to across all six accounts. P2's observation that "women always pick up the slack" captures a dynamic most accounts reflected: That domestic and relational labor expected of women function as a daily performance standard that ADHD makes harder to meet, and that the consequences of failure fall differently on women than on men. She notes that men with ADHD can more readily get away with disorganization because social expectations of male competence were lower, a differential that renders female ADHD invisible in part because women compensate: "Women always picks up the slack. And I think even as children, women was expected to be silent, stay in one spot, doesn't answer back, don't be too loud – and guys just get to do whatever… [M]y husband just got diagnosed with ADD… [I]t didn't really matter to him till now… [T]ill today nobody care. It's so different for women. I cope up with it with anxiety… I'm literally running on anxiety, because that day if I don't wake up with anxiety I know I won't get nothing done."

P4 describes the gendered dimensions of her care in concrete terms. Her psychiatric consultation, she notes, focused heavily on domestic tasks, cooking, and morning routines rather than on professional functioning or broader quality of life. Her mother-in-law's refusal to acknowledge her diagnosis was experienced within a framework of domestic expectation: She was expected to fulfill the role of a traditional wife regardless of her neurodevelopmental profile. Her response to deliberately and strategically fail to meet certain gendered expectations, a form of intentional resistance, was notable as an act of self-preservation rather than passivity: "I had to constantly keep let down everyone on purpose just so they understand the message that just because my husband are now married to me doesn't mean I take over every responsibility… I would simply say, I'm on my way to a session's, I don't know you calls him directly… [E]ventually they gets the message."

Masking as gendered performance

The theme of masking, which appears in Theme 1 as a diagnostic barrier, reappears here as a gendered practice. Participants describe masking not only as an adaptive response to an unsupportive environment but as a performance shaped by specifically feminine social expectations. P1's account captures this with particular force: The distinction P1 draws between surviving and living is significant. It situates masking not as a coping strategy among others but as a baseline condition of female existence under the social expectations she experienced as a continuous and exhausting performance whose alternative, in her account, was not available. P3 observe in parallel that ADHD behaviors were more normalized and more tolerated in men, and that the hyperactivity, impulsivity, and disorganization associated with the condition were culturally legible as masculine in ways that created social permission for men that women did not receive.

This gendered dimension of masking has implications beyond diagnosis. It means that the compensatory strategies women develop are themselves products of a social environment that demands higher standards of self-regulation from women and that the toll of maintaining those strategies, across years and decades, is a dimension of ADHD experience that standard clinical frameworks may not adequately account for.

A counterpoint, and the cost of disclosure

It is important not to flatten the gendered dimension of these accounts into a single direction. P6 articulated a distinct and partly contrasting view: That in the Indian context, men may face greater difficulty than women in speaking openly about mental health at all. Drawing on her experience among male peers in a psychology cohort, she observed that disclosure of a condition like ADHD seemed harder for men, who in her account more often met such disclosure with derision than with empathy. This does not contradict the other participants' accounts of gendered dismissal within clinical and domestic settings; rather, it adds a further layer that the social sanctions around mental health operate on men and women differently, and that the relative ease with which some women in this sample could name their condition to peers coexisted with the gendered clinical and domestic burdens documented above. Notably,

P6 also diverged from P2 and P4 on domestic expectation: she described genuinely enjoying household tasks, and did not experience them as an imposed gendered burden. Holding these differences visible, rather than smoothing them into a uniform narrative, is consistent with IPA's idiographic commitment.

P6's account also surfaced a distinct cost of disclosure not present in the other interviews: The appropriation of her diagnosis by others. She describes peers who, once aware of her ADHD, began to treat it as a license for her to evade responsibilities, or who casually claim the label themselves in ways that diminish its meaning for her. She draws a sharp line between clinical reality and casual self-identification: "My friends started taking advantage on that fact. They started assuming that I am gets away with things because I have ADHD… being diagnosed with ADHD and calling yourself as having a ADHD are two different things."

This dynamics, which P6 links to the wider trivialization of ADHD on social media, produce a specific exhaustion: In a context she experienced as culturally conservative, she felt obliged to explain what ADHD actually is before she could safely disclose that she had it. The diagnosis, hard-won and personally significant, were thus rendered socially precarious – simultaneously dismiss by some as fashionable affectation and seizes by others as a convenient excuse. For P6, both responses miss the reality of living with the condition.

The absence of a research mirror

A final and striking feature's of these accounts was participants' awareness of their own absence from the research literature. P1 had independently searched for published research on adult ADHD in Indian women and found only one paper from another Indian city. She named this absence not as an abstract observation but as a lived experience of invisibility, the sense that the professional knowledge base she worked within had not been built with people like her in mind: I always try to learn about it before getting into anything. I was trying to read [about] all this. I had no… I was not even able to read any articles because nothing was existing. Then finally, I think… [a researcher in another Indian city] her article only [exists]. I think that was the first article. P3 identified social media as filling the void left by the absence of credible, culturally grounded resources and noted the risks that came with this, as misinformation circulated widely alongside genuinely useful peer accounts. P6, approaching the literature from within organizational psychology, made a parallel observation: the little research she could find concentrated on boys and teenagers, leaving adult women, and adult ADHD in workplace and organizational contexts, conspicuously unrepresented. The absence of Tamil Nadu-specific evidence, and the near-total absence of South Indian urban contexts from the ADHD literature, means that both clinicians and patients in Chennai are navigating without an evidence base that reflects their reality.

DISCUSSION

The systemic character of barriers

The central argument of this paper is that the barriers to ADHD diagnosis and post-diagnostic care encountered by this sample are structural and gendered rather than knowledge-based. The evidence for this claim is the sample itself: six women with postgraduate psychology training or advanced training in the field, working in or entering mental health professions, who were nonetheless unable to access timely, adequate, and coordinated care.[17] If knowledge were the determining variable, these women would have been the most advantaged group possible. The fact that they were not points firmly toward the structural conditions described by Andersen's enabling factors: cost, geography, availability of specialists, and systemic coordination as the primary determinants of access.

Within Andersen's framework, the enabling factors recurring most consistently were financial cost, geographic fragmentation, and absent specialist availability not individual deficits but features of how ADHD care is organized in Chennai's private sector, where the absence of any coordinated post-diagnostic pathway leaves each participant assembling care from disconnected providers at personal cost.

The gendered diagnostic gaze

The feminist mental health framework illuminates dimensions of these accounts that Andersen's model, in its structural focus, cannot fully capture. The clinical redirection toward anxiety, the linguistic evasion of the ADHD diagnosis itself, the focus on domestic functioning in psychiatric consultation, the dismissal of participants' own clinical knowledge these are not random failures of individual practitioners. They are expressions of what Ussher describes as the tendency within the clinical system to translate female distress into more familiar, more manageable, or less contested categories.[5]

The consistent appearances of anxiety as an alternative explanatory frame is significant given the literature on ADHD-anxiety comorbidity. While the two co-occur frequently, as in P5's case, where both were diagnosed, anxiety is not ADHD; their substitution in clinical encounters represents a diagnostic failure with material treatment consequences,[2] and its recurrence across multiple participants and professionals suggests systemic rather than idiosyncratic patterns.[18]

The insider-outsider paradox

Drawing on Collins' concept of the outsider-within, structurally positioned within a dominant institution while remaining marginalized by it, these participants were professionally fluent in mental health care yet unable to convert that

fluency into better personal outcomes.[19] The barriers were not addressed by information or awareness, because these women already had both. What they lacked was a system organized to respond to their needs: affordable specialists, coordinated referral pathways, gendered-assumption-free clinical encounters, and flexible medication management. Professional knowledge, in the absence of these structural conditions, conferred understanding without access.

Contextual specificity

The Chennai context shapes these accounts in several distinct ways. The concentration of ADHD specialists in particular parts of the city created geographic barriers that were explicitly described as deterrents to care. The cost of private assessment and ongoing treatment was prohibitive for participants who were not financially independent, a reminder that professional training does not guarantee financial security, particularly for early-career women in freelance or part-time roles. The cultural context adds further complexity: participants described social environments in which ADHD was associated with childhood or with particular social or political circles; in which medication carries stigma even among peers who were broadly supportive of mental health discourse; and in which the absence of a regional evidence base leaves both clinicians and patients navigating without culturally grounded guidance's.

Regional differences within India are themselves a momentous dimension of the admittance picture that national-level policy focus may obscure.

Limitations

Several limitations of this study should be acknowledged. The sample is small and purposive, consistent with IPA's idiographic orientation but precluding generalizations to all women with ADHD in Chennai or India. All participants were mental health professionals or advanced trainees in the field, which was a deliberate design feature of this focused paper but limits transferability to other occupational groups.[20] Recruitment via social media and professional networks may have introduced selection bias toward participants already engaged with ADHD discourse and communities; one participant was known to the researcher prior to the study, as discussed in the reflexivity section.[21] Interviews were conducted in English, which, while the preferred language of all participants, may have excluded women for whom Tamil or other regional languages would have facilitated fuller self-expression.[22]

IMPLICATIONS FOR PRACTICE AND POLICY

The findings of this study carry implications at three levels: clinical practice, professional training, and mental health policy.

At the level of clinical practice, the findings point to an urgent need for ADHD-specialist provision that is geographically distributed, financially accessible, and oriented toward adult presentations in women.[23] Post-diagnostic care pathways that are clear, coordinated, and communicated at the point of diagnosis are absent and needed. The account of a participant prescribed olanzapine off-label without disclosure of its metabolic side effects underscores that informed consent is not a peripheral courtesy but a central component of safe, trust-preserving cares

At the level of professional training, the findings reinforce the need for ADHD-specific content in psychology and psychiatry curricula that addresses female presentations, the role of masking in diagnostic delay, and the interaction between ADHD and comorbid anxiety. The clinical encounters described by participants, including the psychiatric refusal to name the diagnosis, the therapist who reframed the diagnosis as a crutch, the failure to disclose medication side effects, and the repeated redirection toward anxiety, suggest that these are not rare failures but training gaps. That several of the most dismissive responses came from senior figures within psychology itself, including doctoral-level academics, indicates that the gap is not confined to under-trained practitioners but extends into the discipline's own institutions. Equipping clinicians and educators to recognize, name, and respond appropriately to ADHD in adult women is a prerequisite for addressing the barriers this study documents.

At the level of policy, the findings point toward the need for ADHD to be more explicitly addressed within India's mental health policy frameworks, including the Mental Healthcare Act 2017 and associated national programs. Currently, ADHD in adults receives limited specific attention within policy documents that are oriented primarily toward severe mental illness.[24] The extension of affordable, quality-assured ADHD assessment and treatment within public and semi-public mental health systems would address the financial and geographic barriers most consistently reported by participants. The development of culturally contextualized, regionally grounded resources in Tamil and other regional languages, addressing the specific sociocultural context of urban South India, is a practical step that the research community can begin to take.

CONCLUSION

This study finds a paradox: Women who knew the system could not reliably use it. Diagnosis arrives through contingency rather than pathways. Post-diagnostic care was fragmented, costly, and variable in quality. Clinical encounters were shaped by gendered assumptions that deflected rather than addressed participants' needs. The support that sustained these women most consistently was not the formal care system but the informal structures they had built themselves.

The implications are clear. The barriers to ADHD care for women in Chennai are structural and gendered, not informational. They will not be addressed by awareness campaigns or individual advocacy alone. They require a coordinated post-diagnostic pathway, accessible specialist provision, clinical training that centers female presentations, and a research base that reflects the reality of adult women with ADHD in South Asian urban context. This study is a contribution toward that base and a call for the field to take the experiences it documents seriously.

REFERENCES

1. Quinn PO, Madhoo M. A review of attention-deficit/hyperactivity disorder in women and girls: Uncovering this hidden diagnosis. Prim Care Companion CNS Disord 2014;16:PCC.13r01596.
2. Attoe DE, Climie EA. Miss. Diagnosis: A systematic review of ADHD in adult women. J Atten Disord 2023;27:645-57.
3. Sankaralingam G, Subramaniyan K, Ezhilarasi K, Umapathy D, Rajan Renuka R, Jothinathan MD, *et al*. Induction of ER stress-mediated apoptosis in breast cancer cell line by the powerful alkylating agent bendamustine and insights into its molecular mechanisms. Med Oncol 2025;42:416.
4. Kopp S, Kelly KB, Gillberg C. Girls with social and/or attention deficits: A descriptive study of 100 clinic attenders. J Atten Disord 2010;14:167-81.
5. Ussher JM. The Madness of Women: Myth and Experience. London: Routledge; 2011.
6. World Health Organization. Mental Health Atlas 2020. Geneva: WHO; 2021.
7. Young S, Adamo N, Ásgeirsdóttir BB, Branney P, Beckett M, Colley W, *et al*. Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/hyperactivity disorder in girls and women. BMC Psychiatry 2020;20:404.
8. Shidhaye R, Kermode M. Stigma and discrimination as a barrier to mental health service utilization in India. Int Health 2013;5:6-8.
9. Azeez S, Rahim PA, Sudarson J, Ryntathiang I, Jothinathan MK, Ramalingam S. Chitosan from *Rhizopus stolonifer*: Process optimization, structural characterization and selective antimicrobial activity. J Ayurveda Holist Med 2025;13:25-37.
10. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, *et al*. National Mental Health Survey of India, 2015-16: Prevalence, Patterns and Outcomes. Bengaluru: NIMHANS; 2016.
11. Lakshmikanthan M, Ramalingam S, Muthu S. Fucoidan-based PEGylated $MnFe_2O_4$ nanocomposites: Characterization, *in vitro* release behavior, and anticancer activity against A549 cells. Food Hydrocoll Health 2026;10:100300.
12. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? J Health Soc Behav 1995;36:1-10.
13. Stoppard JM. Understanding Depression: Feminist Social Constructionist Approaches. London: Routledge; 2000.
14. Priya MD, Ramya S, Ramalingam S. Integrative network pharmacology, molecular docking, and *in-vitro* analysis of the antidiabetic potential of diosmin. J Ayurveda Holist Med 2026;14:13-27.
15. Smith JA, Flowers P, Larkin M. Interpretative Phenomenological Analysis: Theory, Method and Research. 2nd ed. London: SAGE; 2022.
16. Barkley RA. Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 4th ed. New York: Guilford Press; 2015.
17. Nandhini MS, Lakshmi K, Shoba T, Ramalingam S. Gut microbiota dysbiosis and its correlation with viral load in chronic hepatitis B patients from Chennai, Tamil Nadu. Bangladesh J Med Sci 2026;25:S154-8.
18. Saravanan N, Rajagopal S, Kumar P, Jagadeesan M, Srinivasan MK, Ramalingam S. Optimization of cultivation parameters and evaluation of nutritional and *in-vitro* antioxidant properties of *Macrocybe gigantean*. J Nutr Food Secur 2026;11:489-503.
19. Collins PH. Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. 2nd ed. New York: Routledge; 2000.
20. Thangamani R, Gautham P, Chelika U, Amuthavalli A, Anibriteena F, Sudarson J, *et al*. Phytochemical profiling, antioxidant evaluation, and anticancer potential of *Azolla pinnata* methanolic extract: *In vitro* and *in silico* insights. Int J Nutr Pharmacol Neurol Dis 2026;16:317-29.
21. Harding S. Whose Science? Whose Knowledge? Thinking from Women's Lives. Ithaca: Cornell University Press; 1991.
22. Keerti VK, Prasad M, Ramalingam S. Synergistic computational and cellular investigation of berberine's therapeutic potential in triple-negative breast cancer. J Ayurveda Holist Med 2025;13:12-25.
23. Chelika U, Merriwin D, Mathiyazhagan S, Selvankumar T, Ramalingam S. Integrated *in vitro* and *in silico* assessment of the antidiabetic potential of friedelin: Enzyme inhibition and putative insulin-signaling targets. Int J AdvSciEng 2026;13:7566-77.
24. Nadeau K, Littman E, Quinn P. Understanding Girls with AD/HD. New York: Advantage Books; 2002.

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