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Academic Paper

The experience of coaching for women with a late diagnosis of attention deficit hyperactivity disorder (ADHD)

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Abstract

An ADHD diagnosis can be disorientating, unsettling and validating. Females are less likely to be diagnosed in childhood and, despite being recommended as part of multi-modal treatment plans, there is little research into coaching for women with adult ADHD diagnoses. This study employed a qualitative interpretative phenomenological analysis (IPA) approach, and utilised a heuristic framework for data analysis. Participants found coaching beneficial in identity reconstruction post-diagnosis, particularly through psychoeducation, executive function training, and exploring the impact of undiagnosed ADHD on self-esteem. This research sheds light on women's experiences with later-life ADHD diagnosis and coaching, contributing to an understanding of the process.

Keywords

ADHD coaching, women, diagnosis, adult

Article history

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Introduction

This paper investigates the coaching experience of women diagnosed later in life with attention deficit hyperactivity disorder (ADHD). Only 25% of adults with ADHD are diagnosed as children (Faraone *et al.,* 2004) and three times more boys than girls are diagnosed in childhood. This changes to 1:1 in adulthood, suggesting an alarming lack of diagnosis in girls (Da Silva *et al*., 2020) and a gender disparity in male vs female diagnosis. Females are likely to be undiagnosed or mis-diagnosed due to a lack of understanding and research of the effect of gender difference on the manifestation of symptoms (Quinn, 2004, 2008). This has had the result of women not only failing to fulfil their potential and having 'significant consequences for all areas of [...] functioning' (Painter *et al*., 2008, p.178) as well as leaving them struggling with relationships, self-esteem, financial and mental health issues (Henry & Hill Jones, 2011).

A diagnosis helps with self-acceptance (Waite 2010; Stenner *et al.,*2019) as well as helping with feeling in control of symptoms (Bartlett *et al*., 2005; Henry & Hill Jones, 2011; Stenner *et al*., 2019). ADHD can be a manageable condition and diagnosis and treatment can immensely improve the outcomes for children with ADHD (Quinn, 2004). Medication is usually the first point treatment for ADHD (Rostain & Ramsey, 2006), however there are ongoing supply issues at the time of writing (Royal College of Psychiatrists, May 2024). Additionally, medication does not address the psychological impact of a later life ADHD diagnosis, nor does it help with coping skills and strategies (Ramsey & Rostain, 2005).

Access to treatment is problematic. A misunderstanding of the male/female difference of symptom manifestation creates a barrier to referral (Millenet *et al*., 2018; Young *et al*., 2020) as does both a lack of awareness of the negative outcomes for undiagnosed ADHD in females (Mowlem *et al.,* 2019) and the lack of resources for specialist ADHD diagnosis and treatment. The NICE guidelines in 2018 particularly addressed the issue of ADHD being under recognised in women and girls (NICE NG87, 2018).

Medication is helpful for the management of challenging symptoms in some people (Surman *et al*.,2013), but many people feel that they are left without support to process the impact that living with undiagnosed ADHD has had upon their lives and are unsure how best to learn and implement effective tools and strategies (Ramsey & Rostain, 2005).

Young *et al.,* (2020) found that, whilst older women experience the same problems as girls regarding relationships, risk-related behaviours and core ADHD symptoms, psychosocial treatments additionally need to address gender-related behavioural expectations, such as managing increasing demands of home, work, parenting, and family. The majority of unpaid care work is still being borne by women, exacerbating the challenges of women with ADHD, which are unlikely to be experienced in the same way by men with or without ADHD (Treas & Tai, 2016; Ferrant, Pesando & Nowacka, 2014; Age UK, 2019). Millenet *et al*., (2018) highlight that identical behaviour in men and women is likely to produce different reactions due to gender-based societal expectations. Ussher (1991, p.139) wrote that women were more likely to be viewed as ‘mad’ for not complying with ‘stereotypes of femininity’. Holte and Langwik (2017) found that women were acutely aware of the struggle between gender norms and symptoms attached to ADHD; these women reported coaching to be supportive in helping their self-efficacy, self-awareness, and self-esteem.

Coaching for ADHD is suggested as a useful intervention as part of a multi-modular treatment programme for ADHD (Ramsey & Rostain, 2005). However, there is little research into what this might look like, in particular for women with later life diagnoses, bearing in mind the different manifestation of symptoms in males and females. Prior to diagnosis women are likely to blame themselves for being lazy, stupid or different (Lynn, 2019) and have destructive coping strategies (Bartlett *et al*., 2005; Pinkhardt *et al.,* 2009; Stenner *et al.,* 2019); coaching for women diagnosed with ADHD in later life needs to take this into account.

This research looks into women’s experience of ADHD specific coaching, following later life diagnoses and uncovers patterns experienced by the women during their lives, both before and after diagnosis concluding that coaching was beneficial both on an emotional and practical level. The overarching theme that emerged from analysis of data was that of ‘identity,’ the impact that the coaching experience had upon participants’ understanding of themselves and their understanding of how they fit into society. All participants found that ADHD coaching positively enhanced their lives. This research shows that whilst it is important to address executive function skills in later diagnosed females, psychoeducation and processing how ADHD has impacted their lives, are also important. The implication is that coaching for those diagnosed with ADHD in later life should be a three-pronged approach to cover these areas.

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Literature Review

'Females who have ADHD are an underrecognized, understudied, and insufficiently treated subgroup' (Quinn, 2005, p.585).

There is very little research on females, whether medical, regarding diagnosis (with the result that at one point males made up 80% of all people diagnosed) treatment focused, or experiential (Nadeau & Quinn, 1999). It is becoming better understood that symptoms, comorbidities, and behaviours of females and males withADHD differ (Millenet *et al*., 2018; Young *et al*., 2020). Little has been studied as far as older adults with this condition are concerned (Young *et al.,* 2020) in particular the impact of an adult diagnosis of ADHD on women (Henry & Hill Jones, 2011).

A multimodal approach to treatment is recommended, including neurobiological/ pharmacological, psychoeducation and psychosocial interventions (Ramsey & Rostain, 2005**;** Emilsson *et al*., 2011**;** Murphy, 2005; Weiss *et al*., 2012) and whilst coaching is considered a useful intervention within this framework (Quinn, 2005; Waite, 2010; Murphy, 2005; Kelley, English, Schwallie-Giddis & Jones, 2007; Schrevel *et al*., 2016) almost no research has been conducted into what that might look like for older women.

ADHD coaching has, in the main, focussed on helping college students academically by improving executive function skills challenges. Much of the small amount of research regarding ADHD coaching focuses on adolescents and college students - with no differentiation in gender- the main aim being academic improvement. A comprehensive literature review into coaching outcomes for college students with ADHD found 19 qualitative and quantitative studies, all of which identified that coaching helped with executive function and ADHD symptoms (Ahmann *et al.,* 2018). Studies of coaching for undergraduates with ADHD suggest that an improvement in executive function skills can be linked to an improvement in autonomy leading to increased confidence and positivity for the future (Parker & Boutelle, 2009; Swartz, Prevatt & Proctor, 2005). An empirical evaluation conducted by Prevatt and Yelland (2015) of a coaching model (Ramsay & Rostain, 2005), which included psychotherapeutic techniques combined with CBT and psychoeducation about ADHD, life management and executive function skills, self-esteem, and emotion management strategies, showed positive improvements in all areas consistent over the five years of the study. This suggested that ADHD coaching should take a comprehensive approach, rather than be purely focussed on executive function skills.A strengths based coaching model was found to be 'a key support in the attainment of goals, and leads to greater need satisfaction and well-being' (p.6). assisting in subjective psychological well-being (Linley *et al*., (2010).

The very small amount of research conducted on people diagnosed with ADHD as adults found that the positive, solutions-based focus of coaching helped participants feel more capable,more in control of their futures (Schrevel *et al*., (2016) and had a positive impact on all behaviours (Kubik, 2010).

Existing, non-clinical, research regarding ADHD in adults tends to be focused on the experience of being diagnosed.Studies found that participants had internalised the repeated negativity that had been directed at them throughout their lives; the diagnosis was very important in helping to construct a more positive self-view and to develop hope for the future.Fleischman and Miller (2013) found a complex interaction of experience and Hansson Halleröd *et al*., (2015) found the majority of participants thought their diagnoses a positive development, even though one thought it "the worst thing he had ever experienced (p.3). Participants in a focus group talked offeelings of powerlessness, lack of understanding from others, low self-image and feelings of difference (Schrevel *et al*., 2014).

The limited number of studies focussing on the experiences of women diagnosed as adults, found a prevalence of low self-esteem, self-blame, and social difficulties, along with organisational and

attention difficulties (Holthe & Langvik, 2017). Female participants talk about stigma, shame and feeling different (Stenner, O'Dell and Davies, 2019). These feelings were compounded by misinformation about, and denial of the existence of ADHD in the press, social media and society.

No qualitative research was found that specifically addressed the experience of ADHD coaching for late-diagnosed women. However, Holte and Langvik (2017) found an awareness of the struggle between gender norms and ADHD symptoms, and found coaching to be supportive in helping self-efficacy, self-awareness, and self-esteem. Henry and Hill Jones (2011) found women diagnosed over the age of 60 who engaged in a group therapy program, reported a realisation that they 'weren't alone' (p.258),increased self-acceptance and self-awareness, whilst learning executive function skills and strategies. All participants reported feelings of shame being 'replaced with feelings of pride' (p.258). The research points out the urgent need for empirical research, highlighting that effective assistance has positive implications on women with ADHD at any age.

It is also clear from reviewing the literature that research needs to be conducted investigating the experience of coaching for women with ADHD, in particular those with late diagnosis, as this is currently an almost entirely unresearched field.

Methodology

As there is so little in the way of research focussed on women with ADHD, in particular those with a later diagnosis, it was important to address this by hearing from women themselves and to attempt to understand their perspective through their own personal accounts.

Phenomenology allows readers of a study to "walk a mile" in the shoes of the participants and to learn first-hand how that experience is for the participant. It is the examination of people's experiences and how that experience is understood (Langdridge, 2007).Additionally, Bachkirova, Rose and Noon (2020, p.74) suggest that 'phenomenology has a particular affinity with the coaching process' both being concerned with exploring and understanding experiences from a first-person point of view. As the lens through which each person creates their own meaning-making is entirely subjective and dependent on personal social cultural experience and interaction, researchers cannot separate themselves entirely from how they view their research; it will always be subjective which will inform their interpretation of the research (Oxley, 2016). The aim of interpretative phenomenological analysis (IPA) is to gain a detailed understanding of how people create meaning of relationships, occurrences, and mechanisms in relation to their own lived experience, their 'being-in-the world'; IPA researchers attempt to access that understanding from the point of view of the research participants (Larkin, Eatough & Osborne, 2011).

Given that this was an exploration of understanding of experiences, a qualitative research method was appropriate (Creswell, 2009) particularly as results from qualitative research are accessible to a wider audience than those from quantitative research (Silverman & Patterson, 2021). The method is grounded in the social sciences and as such is a 'truly democratic and empowering approach' (Silverman, 2021 p.3).

Research participants

To provide valuable, profound data enabling perceptive analysis for IPA, it is recommended that the research focuses on a small-scale sample of analogous participants (Smith & Osborne, 2007; Smith *et al*., 2009; Robinson, 2014).For homogeneity, with the indication from the literature that delay in diagnosis increases negative outcomes, the age range was decided to be 40 and above. In addition, participants should have been diagnosed and received coaching fairly recently (for accurate recall sake), at least within the last two years. Two years was chosen, rather than a shorter period of time as waiting lists for diagnostic assessments are extremely long – between six

months and three years according to some reports. It was important, given that this was experiential research, that depth should not be sacrificed for breadth and so a sample size of three was decided on; Smith and Osborne (2007) and Clarke (2010) suggest three participants are sufficient to allow for thorough immersion, whilst providing an opportunity for exploration of divergence and convergence.

Participants self-selected by responding to requests placed on Facebook groups dedicated to women with ADHD, ADHD coaching, ADHD coaching for women, and women entrepreneurs with ADHD. The requests outlined the purpose and nature of the research. Those interested were asked to respond via messenger or email, so that no one felt obliged to take part.Those who did not meet the criteria, for example, having experienced CBT rather than coaching or having been diagnosed before the age of 40 were told why they were not suitable in this instance. Those respondents who did meet the criteria were emailed with further information, including a participant information sheet as Creswell recommends (2012); and asked whether, if they were still interested in taking part, they could arrange a date and time of their choosing for the interview to take place.

At the start of each interview, express permission was sought to interview, record and transcribe the interviews and to use the data in the research. Throughout the process, the right of the participants to withdraw at any point, without having to justify themselves, was emphasised (Wiles & Boddy, 2013). After the interview, each participant was emailed with thanks and a note that they should not hesitate to contact the researchers should they have any questions or concerns.

All the participants in the study were over 40 at the age of diagnosis; they had all either sought coaching following diagnosis (2/3), or whilst on the waiting list for a diagnosis (1/3).

Data collection and analysis

Semi-structured interviews were conducted consisting of nine pre-prepared open-ended questions informed by the literature review and key aspects of the research question. Smith, Flowers, and Larkin (2009) suggest that between six and 10 questions is appropriate for articulate adults, with an expectation that these will cover approximately 45-90 minutes. The questions were prepared in advance as suggested by Wengraf (2001), in order to provide consistency and structure to each interview, whilst at the same time being flexible and adaptable enough to follow where each participants' unique viewpoints and experiences led (Smith, Flowers & Larkin, 2009; Sultan, 2019). The idea was that the questions would provide a framework which could be developed in each interview, within which the participants could talk spontaneously, candidly and unconstrainedly (Smith, Flowers & Larkin, 2009).

The semi-structured interviews were conducted on a one-to-one basis via Skype. Whilst it might be that face-to-face interviews are ideal, in order to reach the 'ideal research sample' a variety of methods may be necessary (Deakin & Wakefield, 2014, p.604) such as networked platforms (Janghorban et *al.*, 2014). Post-pandemic, coaching is increasingly being conducted via media such as Skype or Zoom so online video meetings seemed an appropriate choice as the participants were based in various locations around the UK.

The interviews were recorded, with the participants' express permission. This prevented data from being lost or missed, and also removed the possibility of interruption to the flow and fluidity of the interactions, allowing for elucidation and expansion of answers in actual time.Whilst written interviews could have been considered, such a method did not seem appropriate both in terms of the preferences of target participants or in terms of gathering maximum relevant data. People tend to be more verbally unconstrained than when writing (Giorgi, 2012).

Before transcribing the interviews, notes were taken from each recording. The interviews were then transcribed by an online word-to-text tool and checked against the recordings, both to check for

accuracy and for familiarisation and immersion in the data, as suggested by Bryman (2016). Inflection of speech, tone, the use of pause and body language are important in data analysis of this kind and recording the interviews allowed this to be properly noted. Again, permission was sought from each participant before transcribing.

Coding and analysis

IPA is a flexible research method that can accommodate each individual researcher's purposes (Pietkiewicz and Smith (2014). The research also demanded an analytic method that could combine reflexivity with recognising and identifying themes and patterns so Smith, Flowers and Larkin's (2009) framework for heuristic analysis was utilised in the implementation of the data analysis. This allowed for self-reflexivity and checks on researcher subjectivity during analysis, as well as potentially allowing multiple opportunities for new insights during the process. Ten stages were followed in order to discover themes or patterns; emergent themes and clusters were identified and cross-analysed. The overarching theme of 'identity' was revealed and from this two sub-themes emerged: 1) Who am I? and 2) Why am I ?

Findings

An overarching theme was recognised: 'Identity' which encapsulated two master-themes, each containing three subordinate themes as shown in Figure 1.

Figure 1: Table of Themes

Overarching theme	Master themes	Subordinate themes	Prevalence
1.0 Identity	**1.1 Who am I?** Coaching facilitated a re-evaluation of the *sense* of SELF	1.1.1 Disorientation, doubt, grief, and regret 1.1.2 Relief and validation 1.1.3 Difference: Masking and inauthenticity	3/3 3/3 3/3
	1.2 Why am I? Coaching facilitated a Re-evaluation of the *functioning* of the SELF	1.2.1 Psychosocial education Self-compassion 1.2.2 Unlearning the past Resistance 1.2.3 The coaching relationship Shame/stigma/awareness	3/3 3/3 3/3

Within the overarching theme of 'Identity' participants discussed aspects of identity sense making, composed of two master-themes 1) who am I? - in which the coaching process helped the participants gain insight to re-evaluate their self-identity; 2) why am I? - in which the coaching process facilitated a re-evaluation of the function of the self, gaining insight into the participants' own specific challenges. The master-themes highlighted the importance participants placed on re-evaluating, throughout the coaching process, their previous perceptions of themselves (in their sense of self and function).

All participants spoke of feeling 'different' from childhood; whilst they enjoyed learning, they did very well in subjects with which they had a connection (either with the subject or the teacher) and less well in those that they didn't. All participants mentioned problems with some teachers, being told off for being too talkative, daydreaming, not concentrating etc., as well as problems with friendships, social interaction and misunderstanding (or not understanding) social cues.Participants also experienced these same problems in work environments, and two out of the three participants experienced being bullied in the workplace.

All participants mentioned feelings of relief following their diagnosis as well as disorientation, denial and doubt as they struggled with reconceptualising their identities. They described that, whilst the knowledge gave them the validation they needed, they received no support as to what to do with

that insight.They spoke of frustration, regret and grief of lives spent without diagnosis, blaming themselves and being blamed for something out of their control;an important aspect of the coaching experience was processing that, had they been diagnosed earlier, life would have been easier.

> *It was upsetting. I've spent my whole life thinking that I'm falling short, that I'm a bit of a failure…once I've had it confirmed I am a person with ADHD…that was hard to get my head around.*

> *There is a lot of guilt and shame and frustration - if only we'd known.*

Leading up to diagnosis, all participants expressed feelings of doubt, as if by accepting that they had 'felt different' or struggled due to ADHD they were 'making excuses' for themselves. Doubt seemed to be linked to internalised feelings of self-blame, being harder on themselves than on others, and of feelings of failure. Hearing from a professional that they were not 'less than' or 'making a fuss about nothing' was immensely affirming and validating.

One participant felt doubt prior to diagnosis which transformed into validation:'It was a relief…. because it's hard not to doubt yourself , it was reassuring.'

Coaching helped with processing anger at missed opportunities for diagnosis, and sadness for the loss of what might have been. Participants expressed sorrow and anger that they were not diagnosed sooner:

> *I could have approached it all so differently - that could have completely changed it for me.*

> *I get really really furious.*

> *I'm recovering from all the grief.*

> *I'm kind of in that annoyed stage now. How did none of these therapists pick this up?*

There was an enormous sense of grief, and sadness at the 'not knowing', as participants began to re-frame the past during the coaching process.

> *The grief that I had, that 35 year old grief of not being able to be consistent. That's the hardest part about realising that this is ADHD, that there are reasons why.*

Discovering that you have lived all your life with a neurological difference, realising why you have felt or behaved differently from other people, why you found connection with others confusing, problematic, and difficult, is complex to process.

Participants expressed how important the diagnosis was to their identity sense- making:'I needed the validation that I haven't just been making this up.'

Within feelings of validation, the participants describe a sense of knowing and doubting, an intimation that the diagnosis has brought new knowledge and insight to their concept of identity, whilst still being unsure of what to do with that knowledge.

One participant described the affirming validation and insight she experienced from her coaching relationship

> *The things that he was giving me, the sorts of insights, the questions he was asking me, it just made so much sense of my whole life. I've never had these insights and I've never lined them up. And I couldn't believe it. I just couldn't believe it.*

One participant spoke about the validation, ongoing support and sense of belonging that she got from her group coaching programme:

> *… we've all been supportive of each other in terms of how to process the emotion. I think I'm still processing some of it, but I have a support group, a support network because of the coaching I have done.*

Carl Rogers (1946) believed unconditional, positive regard was necessary in order to create a non-judgemental, supportive place for people to grow and develop. The experience of the participants aligns with this: they had felt different and judged all their lives, to the extent that they were concerned that they would 'fail at coaching'. Experiencing coaching that was validating and non-judgmental was immensely powerful in creating space for self-compassion.

All participants mentioned 'masking' and a sense of 'inauthenticity. Masking means behaving inauthentically in order to fit into different environments, behaving in a way that is socially acceptable, but not true to oneself, in order to fit in and connect with other people. It involves copying other's behaviours, controlling impulses, covering up symptoms and practising reactions and responses. These behaviours can become so unconscious that the person masking is no longer awareand does not understand why they feel uncomfortable, overwhelmed, or inauthentic in situations. All participants mentioned working out what people wanted from them and being able to present that, for short periods of time, but ultimately resulting in exhaustion: 'It was not sustainable; I mean, it costs me because I crash and burn.'

The participants attempted to 'mask' to suit each changing environment but feared being 'found out':

> *I just all the time doubted myself. And I was terrified.*

> *Actually, I realised the other day that a constant throughout, certainly my adult life, has been fear.*

> *I was constantly uncomfortable, constantly waiting for them to find me out.*

They also worked hard to cover up how much they were struggling:

> *On the surface, it all looked fine, because I was achieving.*

People with undiagnosed ADHD still experience the innate human desire for connection, and may mask in order to attempt to create those connections, whilst at the same time re-evaluating their own identities based on negative experiences that these inauthentic connections produce. This identity is constructed from behaviours caused by the symptoms of ADHD in a continual interaction with the individual's environment (Ramsay, 2002; Scarr & McCartney, 1983). Participants reported insights within the coaching experience that made it possible for them to notice and address when and why they behaved inauthentically.

All participants mentioned that coaching which included education about the neurobiology of ADHD was helpful. Understanding the physical and chemical causes of ADHD helped with feelings of failure and self-blame. Psychoeducation may be less relevant for those who have lived with their diagnosis for some time, and who have amassed appropriate knowledge about the neurobiology of ADHD.

The participants also reported the usefulness of understanding neurobiological reasons that they found executive function skills challenging. This helped with visualising the possibility of successfully navigating such challenges, and also positively contributed to self-compassion by

helping them accept it notas the 'character flaw' that had made some things very difficult in their lives.

One participant found that, with her new knowledge of ADHD, she is less self-judgemental:

> *I have these moments where I'm watching something happen and I can't believe I am doing that, but now I know I'm doing that because of XYZ. So actually, that's ok.*

Another found learning specific strategies, based on executive function skills training, helped with prioritisation which in turn reduced overwhelm. She found that her new understanding positively affected her nutrition, exercise, and sleep choices, which in turn impacted how she felt and functioned. Understanding more about motivation and dopamine in relation to ADHD helped with sleep difficulties and eating compulsions and a greater understanding of rejection sensitivity dysphoria also helped with disordered eating based on emotional feelings of deprivation.Rejection sensitivity dysphoria (also hysteroid dysphoria) is a brain-based condition linked to emotional dysregulation in ADHD where a person experiences extreme emotional pain due to feelings of failure or rejection (Dodson, 2016).

Psychoeducation within coaching helped the participants address the regret they felt about situations and behaviours that had occurred in the past.

> *We've gone through our lives hurting people, upsetting people because we were just emotionally dysregulated and we didn't know what was going on, we didn't know how to manage it.*

The participants spoke of the feelings of failure due to trying to emulate a different neurotype, not compatible with the reality of how their brains work.

> *I've spent my entire life thinking that I'm falling short, that I'm a bit of a failure. Why can't I manage when everyone else seems to be managing?*

They gained insight that these feelings of failure were due to symptoms of undiagnosed ADHD and resulting internalised self-blame; coaching helped them exercise self-compassion and move towards autonomy and growth.

ADHD is not caused by negative thoughts about the self, but undiagnosed and untreated ADHD is likely to result in negative thoughts, due to the interaction between the environment and ADHD symptoms (Rostain & Ramsey, 2006). With a later life diagnosis people are forced to radically change their model of belief and their self-perception; this resonates with Mezirow's (1978, 1991) 'disorientating dilemma', a potentially cataclysmic experience in which the person has the opportunity for transformative learning, to grow and develop by changing their life perspective.

This study is concerned with the coaching experience for women with a later life ADHD diagnosis but that experience cannot be looked at in isolation. The literature suggests that living with undiagnosed ADHD is likely to lead to internalised negative views (Fleischman and Miller, 2013), especially for women (Henry and Hill Jones, 2011; Holthe & Langvik, 2017). It was, therefore, important to consider the participants' experiences prior to diagnosis and coaching.

The literature suggests that people with ADHD are more likely to be entrepreneurs and self-employed which was true in all cases in this research. All participants had achieved undergraduate degrees and one had also gained a post graduate degree. Their educational level is stated for numerous reasons: there appears to be a stigma relating to those with ADHD being perceived as less capable (Holthe & Langvik, 2017); and teachers' and parents' expectations for students with ADHD are lower than those for their peers (Batzle *et al*., 2010;Eisenberg & Schneider 2007;Metzger & Hamilton 2021).Additionally, there appears to be a correlation between girls with

high IQ and high verbal IQ being misdiagnosed, undiagnosed, and/or not being diagnosed until older (Nadeau & Quinn, 1999; Holthe & Langvik, 2017). These girls are more likely to suffer from anxiety and depression as the academic challenges increase and previously effective coping strategies are no longer effective (Taylor & Keltner, 2002).Whether lack of diagnosis is due to stigma,lack of understanding of how ADHD presents in girls and women, and/or the efforts that women with ADHD go to in order to attempt to 'fit in', lack of diagnosis andsubsequent treatment comes at great psychological cost. Research shows that women are more likely to internalise negativity expressed towards them by others in reaction to their ADHD symptoms.

It was important to the participants that the coach either had ADHD themselves or had a strong emotional connection to ADHD, via a family member for example. This was in order that they could best understand the challenges experienced and to be able to co-create an equal, non-judgemental relationship, rather than a teacher vs student type dyad (or 'neuro-normal vs neuro-abnormal' dyad), and so circumnavigate any sense of fear of negative judgement. Quinn (2005) reported that women with ADHD often speak of feelings of shame and 'a sense of inadequacy' (p.580). Hansson Halleröd *et al.,* (2015)also mention peoplewith ADHD reporting feelings of 'shame', and being 'judged and disrespected' (p.6), feelings that could unconsciouslylead to distrust and fear of judgement from coaches who don't have ADHD.

Through the experiences of all the participants ran the theme of identity, specifically of authentic identity.Kegan (1982) theorised that humans have two innate tendencies; that of autonomy contrasted with that of integration. For the participants in this study that could be a wish to belong, contrasted with a wish to be able to 'be themselves'.

It is clear from both the literature review and from this research, that the longer it takes to be diagnosed, the more challenges an individual faces. The reasons for this appear to be three-fold. Firstly, without knowledge of an underlying physiological and neurochemical variation, it is difficult to understand the reasons behind certain behaviours or challenges – once diagnosed, it is clear that these are symptoms that can be addressed.This leads to the second reason: the longer people have spent being blamed for symptoms, and the longer these symptoms are misunderstood and presented as personal failings, character flaws and 'moral weaknesses', the longer an individual has to internalise these negative reactions, leading to depression, self-recrimination and issues with confidence and self-esteem, isolation and loneliness.Research has found that women face both higher societal disapproval for symptom manifestation and a higher likelihood of internalisation of this disapproval.Thirdly, it is likely that it becomes more difficult with age to effectively learn skills and strategies to aid with executive function challenges due to less flexible neuroplasticity and the deeper entrenchment of negative or unhelpful coping strategies and habits.

Diagnosis is just the first, albeit important, step.There then needs to be treatment – pharmacological treatment should not be the only intervention, psychological, strategical and behavioural treatment need to take place too. Ramsey and Rostain (2005) found that for treatment for ADHD to be successful, there needs to be awareness that 'cognitive, emotional, and behavioural factors run as deeply as the neurobiological ones' (p.344) and that grief, avoidance and resistance may also need to be addressed.Coaching for ADHD should be strengths based, rather than focussing on lack.

The research participants summed up their need:

> *If I didn't have people around me that were in the same situation, it would be a different kettle of fish completely. I think I would feel quite alone - it's really important to connect with others that are going through the same thing , who understand.*

> *There will be people out there feeling really isolated because they haven't been on a coaching programme or similar and haven't met other people who are ADHD. There should definitely be more support for people. But yeah, there's nothing at all.*

Conclusion

This research looked at the experience of ADHD-specific coaching for women with a later life diagnosis of ADHD. The ramifications of going undiagnosed for so long are not just evident academically, socially, financially, but involve living a large proportion of their life internalising negative views, 'masking', finding it difficult to fulfil societal expectations, feeling 'different', and isolated. Understanding that women are more likely to go undiagnosed in childhood than men is of the utmost importance both in contextualising their needs and experiences within coaching and in highlighting the necessity for ADHD informed coaching. The participants of this research found coaching to be immensely helpful in supporting the re-evaluation of both their sense of self and of the functioning of the self, creating self-acceptance, understanding and autonomy within the reframing of identity.

Possible further research

Very little research was found regarding the coaching experience for adults with a late diagnosis of ADHD, and none specifically concerning women. This is something that urgently needs to be addressed, particularly in light of differential societal expectations and understanding of women with ADHD. More research particularly needs to be conducted into the effects of hormones upon the severity of symptoms, as well as women over 60, who are mostly invisible in ADHD research. This is especially important in light of the high heritability of ADHD.

It would be useful to investigate the experience of group coaching for ADHD in comparison to one to one coaching – group coaching would be more accessible financially and may provide the added element of a supportive community which is not provided in one to one coaching.

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About the author

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