The coping paradox

Why women with ADHD work harder at coping — and what actually helps

Note: The findings in this brief are drawn from 151 women with ADHD who participated in the F'inn survey. This is an analytical subgroup rather than a nationally representative sample of women with ADHD in the United States. These findings should be interpreted as indicative and hypothesis-generating rather than definitive.

Women with ADHD use more coping strategies than women without ADHD. Yet their mental health outcomes are significantly worse. Only **19.9% of women with ADHD** rate their mental health as very good or excellent, compared to **51.1% of women without ADHD**.[1]
More effort. Worse outcomes.

This is the coping paradox. It has direct implications for how support for this population is designed and delivered.

Why this matters

When the coping tools available to women weren't designed for ADHD brains, using more of them doesn't close the gap. Some strategies may even be associated with worse outcomes. Without understanding what predicts good mental health for women with ADHD — and what backfires — organizations, health care providers, and product developers risk reinforcing the very struggles they're trying to address.

Our approach

F'inn, an independent research consultancy, conducted a nationally representative quantitative survey of **3,000 U.S. respondents**. They evaluated 11 areas of life and 152 potential stressors related to mental health and well-being. Through a partnership agreement, F'inn donated the data to Understood.org. Understood's Population Research team used this dataset to conduct a dedicated analysis focused specifically on female respondents with ADHD — an analysis not included in F'inn's published report.

For this work, we focused on **846 female respondents: 151 with ADHD and 695 without**. We used regression modeling to identify the strongest predictors of poor mental health and to test whether coping behaviors work differently for female respondents with ADHD than for those without it.

Mental health was assessed using a five-point self-rated scale. Coping behaviors were grouped into 10 evidence-based categories. Interaction-term modeling allowed us to test whether each category functions differently for respondents with and without ADHD.

Findings

1. ADHD rarely travels alone — and the accumulated burden impacts the mental health gap

Women with ADHD don't just have ADHD. In this sample, **93.4% have at least one comorbid mental health condition**. Women with ADHD live with an average of **4.4 comorbid conditions** — compared to 2.56 for women without ADHD. That's 72% more conditions, on average.

The most commonly reported comorbidities include anxiety, depression, panic disorder, and social anxiety disorder. Anxiety affects **73.5%** of women with ADHD in this sample (versus 56.1% of women without ADHD). Depression affects **67.5%**.[1] The relationship between comorbidity burden and mental health outcomes follows a clear dose-response pattern:

Comorbidity and mental health outcomes

1. **No comorbidities (ADHD only):** 10% report poor or fair mental health
2. **1–2 comorbidities**: 15% report poor or fair mental health
3. **3–5 comorbidities:** 48% report poor or fair mental health
4. **6+ comorbidities:** 74% report poor or fair mental health

This isn't just about having multiple diagnoses. Each additional diagnosis increases the complexity of care. This affects treatment plans and providers' approaches, both medically and psychologically. For women with high comorbidity burden, the logistical demands of managing care may themselves function as a stressor, though this pathway was not directly measured in this survey.

Regression analysis clarifies the mechanism behind the mental health gap. Once physical health and comorbidity burden are controlled for, ADHD status adds no independent explanatory power to mental health outcomes.[1]

The implication is not that ADHD doesn't matter. It's that ADHD doesn't operate in isolation. The comorbidities and physical health challenges it brings with it account for the gap. Addressing ADHD alone is unlikely to close it.

2. Physical health is a top predictor of mental health outcomes for women with ADHD in this sample

Physical health was one of the strongest predictors in the model (β=0.34).[1] **Among women with ADHD in this sample, those who rate their physical health as "Poor" report significantly worse mental health than those who rate their physical health as "Excellent."** This is a gap of approximately two points on the five-point scale. It's an effect larger than any coping behavior in the model.

ADHD literature points to several mechanisms that may explain this association:

- Medication side effects — appetite suppression, GI disruption, sleep disruption — may affect mood and emotional regulation.
- Executive function deficits can interrupt consistent self-care. Irregular eating may destabilize blood sugar and mood. Difficulty initiating exercise may compound ADHD symptoms.
- Sensory sensitivities may generate ongoing low-level physical stress that goes unrecognized.[2]

The strength of this association suggests that physical health warrants routine consideration in mental health support for women with ADHD. Yet it is rarely the focus of such care.

3. Three self-image beliefs are the strongest psychological predictors of poor mental health

Item-level analysis of 12 self-image stressors identified three that show the strongest relationships to poor mental health outcomes among women with ADHD in this sample:

- **"Not living up to your potential"** is the strongest predictor (r=.37), despite not being the most commonly reported source of stress. Only 34% of women with ADHD reported high stress around it. Its predictive strength may reflect how ADHD symptoms — executive dysfunction, working memory challenges, time blindness — generate consistent evidence of not meeting expectations. This belief may function as a lens through which everyday setbacks become confirmation of personal failure.[1]

- **Weight stress** is the highest-reported source of stress across all 12 items (56% report high stress) and the second strongest predictor of poor mental health (r=.28). It's both highly visible and highly felt.[1]

- **Social status** is the third strongest predictor (r=.23). Stress in this domain may reflect ongoing comparison to neurotypical peers, whose milestones and social trajectories can feel more linear. For women with ADHD, the gap between where they are and where they feel they should be is reinforced socially as well as internally.[1]

Across all three items, the pattern is similar: Stress is not always consciously identified as the primary problem, but it tracks closely with mental health outcomes. These findings suggest that the pressures extend beyond situational stress. They may operate at the level of self-concept, though longitudinal data would be needed to confirm this.

Research on ADHD and internalized stigma documents how these pressures may develop. Criticism from teachers, employers, and family members becomes self-criticism over time.[3,4] By adulthood, the belief often feels less like something received from others and more like accurate self-knowledge.[4] This pattern is particularly pronounced for women, whose identity development is more likely to be affected by ADHD-related stigma.[2,5]

4. The coping paradox: More strategies, worse outcomes

Women with ADHD use an average of **9.42 coping behaviors**, compared to 8.27 for women without ADHD. That's **14% more**.[1] Yet they have significantly worse mental health. Why?

Three significant interaction effects show that the same coping behaviors produce different outcomes depending on ADHD status. For several categories, what is protective for women without ADHD either shows no benefit or trends toward harm for women with ADHD.

Standard healthy self-care behaviors show a harmful trend for women with ADHD.

Eating healthy, regular physical activity, sleep routines, meditation, and travel are protective for women without ADHD. For women with ADHD, the same behaviors as a group show a harmful trend (interaction p=.020).[1]

Women with ADHD already attempt these behaviors at higher rates than women without ADHD. But executive function deficits make consistent adherence difficult.[6] Research links guilt and shame in this population to poorer mental health outcomes,[4,7] suggesting that when routines break down, the emotional consequences may themselves compound the problem. This mechanism warrants direct investigation.

Item-level analysis suggests this pattern is driven primarily by **solo, self-regulated behaviors** — eating routines, independent exercise, and sleep habits. These show opposite-direction effects for women with ADHD relative to women without ADHD.

Team sports, however, show a directionally protective pattern for women with ADHD. This is consistent with the hypothesis that external structure and social accountability may offset the self-regulation demands of solo exercise, though this finding requires replication in a larger sample.

The data suggest that how wellness behaviors are structured matters. It's not simply whether someone engages in them.

Creative and expressive activities show protective effects specific to women with ADHD.

Journaling, music, cooking, hobbies, and gardening were significantly protective for women with ADHD (β=−0.191, p=.007).[1] This effect was not significant for women without ADHD (p=.42).

One plausible explanation is that these activities may be particularly suited to ADHD cognition: They provide engagement through novelty. They don't require sustained self-regulation. And they produce visible output. The data suggest they warrant consideration as targeted supports, not merely generic leisure.

Professional support matters more for women with ADHD.

Therapy showed a significantly greater protective effect for women with ADHD compared to women without ADHD (interaction p=.036).[1] This differential effect may reflect the complexity of managing multiple comorbidities, which often requires professional guidance that self-directed strategies cannot provide.

In sum

Women with ADHD use more coping strategies than women without ADHD. Yet they still report worse mental health. The data indicate this isn't a matter of effort. The strategies most available to this population were not designed for ADHD cognition, and several show a harmful trend when applied to this group. The evidence supports a shift toward strategies that are matched to ADHD-specific needs — not more of what hasn't worked.

Implications for research and support

These findings point to specific gaps in how mental health support is currently designed for women with ADHD, and where investment is most likely to improve outcomes.

- **Address the "potential" narrative directly.** Content that reframes this belief as a neurobiological consequence — not a reflection of ability or character — addresses the strongest self-image predictor of poor mental health in this sample. Other Understood research indicates this need is compounded for BIPOC women, who face additional stigma from ableist and racist narratives.[6]

- **Design wellness support specifically for ADHD brains.** Solo, self-regulated routines show a harmful trend for this group. Approaches that build in external structure, social accountability, and flexibility are more consistent with how ADHD affects behavior.
- **Elevate creative and expressive activities as evidence-based therapeutic tools.** These showed significant protective effects for women with ADHD that did not appear for women without ADHD. They warrant inclusion in clinical recommendations and structured interventions, not just in general wellness content.
- **Address comorbidity as a navigation challenge.** Women with ADHD average 4.4 comorbid conditions. Managing this complexity — coordinating providers, tracking medications, navigating insurance — places significant demands on executive function. Support that reduces this burden is likely to have direct mental health benefits.
- **Focus on making professional care more effective.** In this sample, women with ADHD entered mental health treatment at similar rates to women without ADHD (49.0% vs. 48.9%).[1] The gap is in outcomes, not access.

  A systematic review of qualitative studies on women diagnosed with ADHD in adulthood found that professional validation of their struggles — specifically receiving an external explanation for difficulties previously attributed to personal flaws — was associated with significant reductions in shame, anxiety, and depression.[8] This suggests that care that explicitly addresses the neurobiological basis of ADHD symptoms may produce better outcomes, though this hypothesis warrants direct testing.

  Resources that help women prepare for appointments, track symptoms across conditions, and communicate effectively with providers are more likely to move the needle than access-focused interventions alone. This finding should be interpreted with caution given the modest sample size.

A note

The ADHD subgroup in this analysis includes 151 female respondents, which limits conclusions about smaller subgroups. The F'inn sample includes respondents ages 13 and older; findings are not limited to adults. This research is cross-sectional and cannot establish causality. BIPOC women with ADHD are underrepresented in these findings. Additional research with larger and more diverse samples is needed. For more research on women, and BIPOC women, with ADHD, see **Understood's research**.

Connect with us

We're always looking to collaborate and partner with others on our research! Reach out to our team at knowledge@understood.org to learn more.

Methodology

F'inn conducted a nationally representative quantitative survey in 2023 among **3,000 Americans ages 13 and older**. The sample was balanced to reflect the U.S. population across key demographics including age, gender, income, region, and race/ethnicity. The margin of error for the total sample is ±1.7 percentage points at the 95% confidence level. Understood.org's research team conducted a dedicated secondary analysis of F'inn's data-set, focused specifically on female respondents with ADHD — a subgroup not examined in F'inn's published report. This analysis focused on **846 female respondents: 151 with ADHD and 695 without**. ADHD status was based on self-reported current diagnosis. Subgroup margins of error are higher than the total sample margin.

Mental health was assessed using a self-rated five-point scale (1=Excellent, 5=Poor). To identify predictors of poor mental health and test for differential effects by ADHD status, Understood's team conducted hier-archical regression analyses and interaction-term modeling. Coping behaviors (33 items) were grouped into 10 evidence-based categories using a systematic three-step process including empirical correlation testing. Interaction terms (ADHD status × coping category) were used to test whether behaviors function differently for respondents with and without ADHD. All regression results are reported at the 95% confidence level. This research is exploratory and does not imply causation.

References

1. F'inn. (2023). *Stressed out: A call to action. Why and how to prioritize mental health in America*. F'inn. [Secondary analysis focused on female respondents with ADHD was conducted by Understood.org's research team and is not included in the F'inn published report.]

2. Hinshaw, S. P., Nguyen, P. T., O'Grady, S. M., & Rosenthal, E. A. (2022). Annual research review: Attention-deficit/hyperactivity disorder in girls and women: Underrepresentation, longitudinal processes, and key directions. *Journal of Child Psychology and Psychiatry*, *63*(4), 484–496. https://doi.org/10.1111/jcpp.13480

3. Mueller, A. K., Fuermaier, A. B. M., Koerts, J., & Tucha, L. (2012). Stigma in attention deficit hyperactivity disorder. *ADHD Attention Deficit and Hyperactivity Disorders*, *4*(3), 101–114. https://doi.org/10.1007/s12402-012-0085-3

4. Beaton, D. M., Sirois, F., & Milne, E. (2022). Experiences of criticism in adults with ADHD: A qualitative study. *PLOS One*, *17*(2), e0263366. https://doi.org/10.1371/journal.pone.0263366

5. Visser, M. J., Peters, R. M. H., & Luman, M. (2024). Understanding ADHD-related stigma: A gender analysis of young adult and key stakeholder perspectives. *Neurodiversity*, *2*. https://doi.org/10.1177/27546330241274664

6. Wynne, K. J., Sipser, R., & Bassman, J. (2024). *Reaching BIPOC women with ADHD*. Understood.org internal research.

7. Barkley, R. A. (2012). *Executive functioning and self-regulation: Extended phenotype, synthesis, and clinical implications*. Guilford Press.

8. Attoe, D. E., & Climie, E. A. (2023). Miss. Diagnosis: A systematic review of ADHD in adult women. *Journal of Attention Disorders*, *27*(7), 645–657. https://doi.org/10.1177/10870547231161533

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