Gender Differences in ADHD Diagnosis: Implications for Females

By

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Abstract

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder that impacts 3% of the population worldwide and approximately 11% of children. Most of the research on ADHD has been conducted on samples of predominantly males which has resulted in a lack of research and knowledge on the symptom presentation in females. The goal of this capstone is to address the gap in ADHD research on females, as well as analyze the differences in symptom presentation between males and females. This capstone looks at female ADHD diagnosis through the lens of attachment and family systems theories. A proposal for a group session for professionals that highlights the differences in symptoms between males and females is explained in chapter 3.

Keywords: Attention Deficit Hyperactivity Disorder (ADHD), Attachment Theory, comorbidity, emotional regulation, gender differences.

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Chapter 1: Introduction

The diagnostic criteria for attention deficit hyperactivity disorder (ADHD) categorizes symptoms into two categories: inattention and hyperactivity/impulsivity. To receive a diagnosis of ADHD there must be six or more symptoms present in one of these categories (Sanders et al., 2019). Presentation of symptoms differs between males and females; boys are more likely to display hyperactivity / impulsivity symptoms, whereas girls typically display inattention symptoms (Cheng et al., 2022). These differences result in many girls going undiagnosed for long periods of time and missing out on receiving additional support prior to diagnosis. In addition, ADHD affects 11% of children (Boland et al., 2020). Children with ADHD typically perform poorer in school and are only eligible to receive additional academic support if they have received a formal diagnosis (Bussing et al., 2016). The gender disparities regarding diagnosis may result in females not receiving academic support which may result in ongoing academic difficulties over time.

In this capstone, I discuss the symptom differences between girls and boys, gender and referral bias, biopsychosocial factors. This paper will explore the stigma associated with ADHD and how societal norms and gender bias influence the diagnostic process. Additionally, the comorbidities that exist, specifically for girls will be discussed and the impact multiple diagnoses has on their overall wellbeing. A theoretical framework informed by attachment and family systems theories will be introduced to provide a baseline for the development of a workshop for parents, educators, and girls. In the second chapter, I will review relevant literature on gender differences in ADHD diagnosis and explore the role of Attachment theory in ADHD. This

chapter will also explore the ways in which these theories can be applicable for children, families, and professionals.

In the final chapter, I will propose a workshop for parents, teachers, and children to provide them with resources and tools to manage ADHD symptoms in girls and provide psychoeducation about the symptom differences that exist between girls and boys.

Background to the Issue/Problem

The diagnostic criteria for attention deficit hyperactivity disorder categorizes symptoms into two categories: inattention and hyperactivity / impulsivity. To be diagnosed with ADHD, six or more symptoms must be present in one of these categories (Sanders et al., 2019). The first change is the age-of-onset criteria which previously required symptoms to be present prior to 7-years-old; however, it now expands these criteria to require symptoms present prior to 12-years-old (Sanders et al., 2019). A diagnosis requires the presence of "several inattentive or hyperactive-impulsive symptoms" (DSM-5, as cited in Sanders et al., 2019, p. 2) but no longer includes the distinction of symptoms causing impairment.

The presentation of ADHD symptoms in girls typically appears in the form of anxiety, depression, and attention deficits (Klefsjo et al., 2021), whereas school age boys are more likely to display behavioral issues (Klefsjo et al., 2021). The diagnostic criteria for ADHD in adolescence have historically involved samples of predominantly boys, which is a contributing factor to the minimal understanding of how ADHD presents itself in girls (Klefsjo et al., 2021). Additionally, since the diagnostic criteria requires symptoms to be present prior to age twelve, many girls may be excluded from receiving a diagnosis (Cheng et al., 2022).

The prevalence of ADHD in school-age children is a 2:1 ratio between males and females (Klefsjo et al., 2020). During adulthood, this number balances out to a 1:1 male-to-female ratio

(Cheng et al., 2022). The differences in diagnostic age between genders adds to the discussion about the accuracy of the DSM-5 diagnostic criteria on ADHD diagnosis in children.

Anxiety is one of the most common comorbidities with ADHD and has a prevalence of 25-50% (Koyunco et al., 2022). This often leads to diagnostic challenges due to the overlap of symptoms between these disorders. For example, inattention, irritability, and mood instability are all symptoms found in both disorders (Koyunco et al., 2022). Additionally, there are concerns regarding side effects of ADHD medications which may lead to increased anxiety in patients (Koyunco et al., 2022).

Purpose of the Capstone

The purpose of this capstone is to explore the gender differences in the diagnosis of ADHD in childhood. ADHD is often viewed as a predominantly male-dominated diagnosis, so the aim of this paper is to address the gender differences that exist and provide insight into the biopsychosocial factors that impact females. Girls typically present internalizing symptoms whereas boys often have more impulsiveness and hyperactivity symptoms of ADHD (Kok et al., 2016). This paper will also discuss the gender bias that exists in the referral process and its impact on the trajectory of females receiving an ADHD diagnosis. Additionally, the literature review will explore relevant research that will help inform parents, educators, and mental health practitioners.

Research Questions

The research questions that I aim to answer in this capstone paper are:

- What are the primary differences in ADHD symptom presentation between males and females?
- What are some of the biopsychosocial implications for females with ADHD?

- What consequences exist for girls who receive a diagnosis later and have not been receiving adequate academic support previously?
- What are some ways in which teachers / counsellors / parents can support their child (ren) who may be presenting ADHD symptoms?
- How can professionals help to reduce the stigma surrounding ADHD diagnosis?

Significance of the Capstone

This topic is important as ADHD is a prevalent neurodevelopmental disorder that impacts children's development at a critical stage in their lives. The presentation of symptoms that exist between males and females are important to recognize as it can result in females not receiving a diagnosis. This can have a significant impact on their ability to receive adequate academic, social, and emotional support throughout adolescence.

In addition, the mental health field has developed immensely in recent years and parents are faced with numerous obstacles to navigate. Parents could benefit from receiving additional support and resources to better understand what their child(ren) is experiencing and behaviors to be aware of. My hope is that this paper will expand the discussion on gender differences in ADHD and provide parents with more support to navigate their child's diagnosis more effectively.

Teachers spend a significant amount of time with students and observe their behaviors daily which gives them the ability to make recommendations to parents or counsellors for children to complete ADHD assessments. Due to the influential role that teachers play, it would be beneficial if they were provided with resources and tools to observe the presentation of symptoms in female students and were provided with more education about the differences that exist between girls and boys' presentation of symptoms.

Theoretical Orientation

The primary theoretical framework that will be informing my capstone is Attachment Theory. Attachment Theory was developed by John Bowlby (1969) and states that infants develop an internal working model of attachment to their caregiver which can result in a variety of different attachment styles (cited in Storebo et al., 2013). A secure attachment style in childhood is associated with an increased attention span as well as better performance in attention-related tasks (Kissgen & Franke, 2016).

Understanding the role of attachment in early development provides a useful foundation for exploring how differing attachment styles may influence the manifestation and perception of ADHD symptoms, particularly among girls.

This paper will focus on addressing the presentation of ADHD symptoms in girls and how these symptoms differ from boys. The internalized symptoms that girls often display can lead to additional challenges, specifically in social settings. This can lead to lower self-esteem, difficulties with peer relationships, and depression (Quinn & Madhoo, 2014). The societal expectations for acceptable behaviors for boys and girls are very opposing, which may lead girls to internalize their symptoms to avoid being ostracized by their peers.

Throughout this paper, the terms “females” and “girls” will be used. These terms are used to provide a comparison between the presentation of ADHD in boys and girls; however, this paper aims to respect all gender identities.

Positionality Statement

I would like to acknowledge my position as a white, cisgender, middle-class settler. I do not have any children and am not married currently. I grew up in a predominantly white

community, and my experiences are limited as to the populations that I have worked with and the community within which I was raised.

Most of my experience has been working with neurodivergent children and youth which motivated me to pursue a career in this profession. I was made aware of the numerous obstacles and limitations that neurodivergent individuals are faced with, which has contributed to my desire to advocate for and educate myself on ways to address these inequalities. I also worked at an elementary school with some children who were in the process of being diagnosed with ADHD. One of the prominent issues that was brought to my attention is the stigma associated with a child being diagnosed with ADHD. I noticed how much of an impact it had not only on the child but the parents, teachers, and students. I was especially interested in learning more about the gender differences as there appeared to be a higher number of males in comparison to females that received a diagnosis for ADHD.

Definition of Terms

Attachment Theory

This theory was developed by John Bowlby and Mary Ainsworth based on their research of mother-child interactions which resulted in the development of four unique attachment styles (secure, insecure dismissing, insecure preoccupied, insecure disorganized) (Storebo et al., 2013).

Attention Deficit Hyperactivity Disorder (ADHD)

Waltereit et al. (2023) define ADHD as a childhood-onset neurodevelopmental disorder that is characterized by developmentally inappropriate behaviors that impair attention, cause impulsivity, and increase levels of hyperactivity. Often these symptoms continue into adolescence and adulthood, but many individuals can manage their symptoms more effectively.

Comorbidity

A comorbid condition results when there are more than one co-occurring disorder present in the same individual. Comorbid disorders often inform the treatment and provide useful information for therapists. (Hersen & Sledge, 2002).

Emotional Regulation

The process in which an emotional state either increases or decreases. It plays a role in social skill development, academic achievement, and overall health (Ibrahim, 2025). Gottman and Katz (1989) describe it as an individual's response to an emotion that results in either inhibiting a behavioral response, self-soothing, refocusing of attention, and organizes behaviors to respond appropriately to an external goal.

Gender Differences

Refers to differences that exist between genders that are informed by cultural and societal norms. (APA Dictionary of Psychology, 2023).

Chapter Summary

In this chapter, gender differences in the diagnosis of ADHD between males and females was discussed. Relevant research findings were discussed, specifically the referral bias that exists due to the presentation of symptoms in males. Since ADHD is often associated with hyperactive or impulsivity in society, females may be overlooked as they typically have more internalizing symptoms (Klefsjo et al., 2021). This difference may result in females not receiving a diagnosis as they are not displaying the symptoms that are most often associated with ADHD. In addition, this chapter introduced some gaps in ADHD research on females, limitations to receiving care, as well as the theoretical orientations that will be informing the proposed workshop. The aim of this paper is to expand on the previous research and act as a framework to educate teachers, parents, and counsellors.

In chapter two, I will discuss relevant research on ADHD and its implications for females. This chapter is organized into distinct categories: symptom differences between genders, clinician and referral bias, implications for receiving a diagnosis later in life, and systemic / attachment theories. The purpose of this chapter is to critically analyze research on this topic and provide a foundation for chapter three, which will propose a workshop for females with ADHD.

In chapter three, I discuss a proposed workshop for parents and girls with ADHD. I will include an outline for a possible intervention strategy that seeks to bridge the gaps in care for females with ADHD. The theoretical orientations that are informing this workshop will be presented and discussed in detail to provide the building blocks for the proposed intervention strategies.

Chapter 2: Literature Review

In this chapter, I will discuss relevant research on gender differences in symptom presentation of ADHD, clinician and referral bias, and implications for receiving a delayed ADHD diagnosis in females. ADHD is divided into three subcategories for diagnostic purposes. These categories are ADHD-I, which is predominantly inattentive, ADHD-H, which is predominantly hyperactive-impulsive, and ADHD-C, which is a combination of both types (Bell, 2011). Research on the efficacy of using attachment and family systems theories as a treatment approach will be addressed. In addition, the theoretical framework for the proposed intervention will be introduced.

ADHD is categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (5th ed.) as a Neurodevelopmental Disorder. To receive an ADHD diagnosis, six or more symptoms must be present in the inattention and/or hyperactivity-impulsivity category which have persisted for at least six months "…to a degree that is inconsistent with the developmental level and that negatively impacts directly on social and academic/occupational activities" (DSM-5, 2013, p. 59). See Appendix A for the DSM description of ADHD.

There are three additional presentations of ADHD: combined, predominantly inattentive, and predominantly hyperactive-impulsive. A combined presentation exists when symptoms in both inattention and hyperactivity-impulsivity categories persist for the past 6 months. Predominantly inattentive presentation occurs when the required number of symptoms exist in the inattention category but are not present in the hyperactivity category. Some examples of these symptoms are making mistakes in schoolwork, difficulties maintaining attention on tasks, unable to follow through with instructions, and appearing to not listen when being spoken to (National Library of Medicine, 2016).

The predominantly hyperactive-impulsive presentation occurs when the required symptoms are present in the hyperactivity category but not in the inattention category. These symptoms are displayed when an individual fidgets, leaves their seat at inappropriate times, is unable to play quietly, talks excessively, and has trouble waiting for their turn. It is also required that for any of the presentations to be diagnosed, several of these symptoms must have occurred before the child is 12 years old (National Library of Medicine, 2016).

Gender Differences in Symptom Presentation

ADHD is more prevalent in males than females during childhood with a ratio ranging between 2:1 to 10:1, there are higher male-to-female ratios in clinical samples than population-based samples (Mowlem et al., 2018). This can lead to girls being misdiagnosed or receiving a diagnosis at a later age (Slobodin & Davidovitch, 2019). Research has found that boys are more likely to display hyperactive or impulsive symptoms such as lacking self-control or engaging in aggressive behaviors, whereas girls typically present with inattention symptoms which might appear as difficulties engaging in social settings and being socially withdrawn (Becker et al.,) Another key difference is that girls often have co-existing internalizing disorders (i.e., anxiety) while boys are more likely to have co-existing externalizing disorders (i.e., conduct disorder, ODD). (Slobodin, & Davidovitch, 2019). This may result in girls being overlooked or misdiagnosed which can lead to additional struggles associated with not receiving adequate support and resources. Some of the other characteristics unique to females with ADHD include lower self-esteem, social difficulties, comorbidities of anxiety and affective disorders, and masking certain behaviors to hide underachievement (Quinn & Madhoo, 2014).

A common representation of ADHD in the media involves boys who are disruptive, boisterous, and expressive. This stereotype may contribute to the cultural expectation bias

resulting in referring parties being less attuned to the differing ADHD behaviors in females (Meyers et al., 2020). The symptoms in females may appear less problematic as they often involve more internalizing symptoms and are less disruptive to a classroom setting. The diagnostic criteria for ADHD in adolescence are primarily based on research that has been conducted on boys which plays a role in the lack of understanding of the presentation of ADHD in girls (Klefsjo et al., 2021). Specifically, in the trials developed to create the diagnostic criteria for ADHD, girls only made up 21% of the sample size (Klefsjo et al., 2021). This highlights the need for further research that includes greater sample sizes of girls to improve accuracy in the diagnostic and treatment methods (Platania et al., 2025).

Subtypes of ADHD

There are three subtypes of ADHD, predominantly inattentive, predominantly hyperactive, and combined presentation. Predominantly inattentive (ADHD-I) occurs when an individual meets the criteria for the inattention category but not the hyperactivity category. Predominantly hyperactive (ADHD-H) occurs when an individual meets the criteria for the hyperactive category but not the inattentive. A combined presentation (ADHD-C) occurs when symptoms in both the inattention and hyperactivity category are met (DSM-5, 2013).

There has been speculation surrounding the subtypes of ADHD as they may not remain stable over time. In a study conducted by Lahey et al., (2005), researchers found that children diagnosed with ADHD-I or ADHD-H often received a diagnosis of ADHD-C later. (Bell, 2011). This finding suggests that there may be a better method of conceptualizing ADHD as children often move between subtypes over time. In addition, there has been criticism about whether ADHD-I should be its own separate disorder as the symptoms and demographics differ from ADHD-C (Bell, 2011). Females typically display symptoms that align more closely with an

ADHD-I diagnosis; however, the predominant symptom of inattention is drastically different to hyperactivity. This research suggests that it may be beneficial to update the diagnostic criteria for ADHD to better encapsulate the complexities of the disorder.

Clinician and Referral Bias

One of the criticisms of the research on ADHD is that a significant portion of the research studies use subjective scales to gather data (Slobodon & Davidovitch, 2021). Since the diagnosis of ADHD in children is heavily reliant on parent and teacher rating scales, they are at a greater risk of being influenced by reporter's bias which can lead to inaccurate findings (Quinn & Madhoo, 2014, as cited in: Slobodin & Davidovitch, 2021). The results may be biased and may not accurately represent gender differences in the diagnostic process due to girls internalizing symptoms which may not appear to be as problematic. In this study, the Conners ADHD Index Rating Scale, 3rd edition was completed by parents and teachers. It is used to assess children ages six to eighteen years and includes questions pertaining to the child's performance in a school setting, social situations, and at home (Slobodin & Davidovitch, 2021).

Referral Bias

Referral bias is a prominent factor that is likely to have an impact on the referral process for children with ADHD. Papageorgieau et al., (2008) found that girls were less likely to be referred for ADHD treatment even if they were displaying the same or more impairment than boys. Comorbid psychiatric disorders are more prevalent in females which can often result in females being diagnosed with a different disorder. Furthermore, since females typically present internalized symptoms, these symptoms may be interpreted as anxiety and / or depression (Morley & Tyrrell, 2023).

There are also differences that exist depending on whether the child is referred by a clinician or is from a community-based sample. The ratio for clinical samples ranges between 9:1 to 2:1, however, in community-based settings, boys are diagnosed two to three times more than girls (Papageorgieau et al., 2008).

Since children spend a significant amount of time in a classroom setting, teachers are often responsible for recommending a child to receive an ADHD assessment. In a study by Pisecco et al., (2001), teachers were more likely to refer boys as they believed medication would be more useful in treating their symptoms. Additionally, since girl's symptom presentation often involves internalizing symptoms, teachers were more likely to believe their symptoms could be resolved through classroom interventions and did not require external services (Pisecco et al., 2001; as cited in Coles et al., 2010).

Biopsychosocial Implications of Females Receiving a Delayed Diagnosis

ADHD is associated with numerous adverse outcomes which create additional challenges for females who are undiagnosed. Some of these challenges include externalizing and risk-taking behaviors, accidental injuries, social difficulties, substance use disorders, criminal or delinquent activities, suicidality, and academic difficulties (Skoglund et al., 2024). In their population-based cohort study, Skoglund et al also found that females were diagnosed with ADHD approximately 4 years later than males (23.5 years vs. 19.6 years) which caused additional challenges. For example, Skoglund et al. (2024), researchers found that females with ADHD were more likely than males to engage in self-harm behaviors (5.0% vs. 1.6%). Some of the predictors of self-harm behaviors are low self-esteem, poor executive functioning, and severity of ADHD symptoms (O'Grady & Hinshaw, 2021). In addition, the prevalence of suicide increased significantly if the individual also had a history of childhood maltreatment (O'Grady & Hinshaw,

2021). These research findings highlight the need for early intervention and diagnosis for females with ADHD to reduce the risk of suicidality and self-harm behaviors.

Additionally, females learn to mask their behaviors as a coping strategy which can lead to symptoms going unnoticed for a longer duration; however, in adulthood females display more symptomatology as well as more severe anxiety, major depression, and suicidal behaviors (Skoglund et al., 2024). Camouflaging is a term used to describe individuals who suppress certain socially unacceptable behaviors to engage in behaviors that are neurotypical (McKinney et al., 2024). An example of this would be to develop strategies to avoid engaging in certain situations that may provoke certain behaviors perceived as socially unacceptable (McKinney et al., 2024).

Academic Challenges

One of the primary reasons for an ADHD referral in childhood is due to difficulties that arise at school (Tamm et al., 2021). Research suggests that as many as 30% of children with ADHD achieve lower academic performance measured by their age and IQ (Thorell, 2007; as cited in Tamm et al., 2021). Additional academic support is available for children with ADHD if they have received an ADHD diagnosis, however, many females may miss out on receiving this support if they remain undiagnosed until later adolescence or adulthood (Bussing et al., 2016). Undiagnosed females with ADHD often manage their symptoms for many years without the appropriate tools and behavioral skills to effectively treat their symptoms.

Females with ADHD often experience fewer academic challenges than males until they reach university, where these difficulties become more prominent (Morley & Tyrrell, 2023). Specifically, females may find it challenging to develop interpersonal relationships, participate in team activities, and work on group assignments (Sedgwick-Muller et al., 2022, as cited in

Morley & Tyrell, 2023). This may be a result of increased responsibilities and moving away from home which may exacerbate underlying ADHD symptoms such as interpersonal difficulties, maintaining academic requirements, and anxiety / depression (Quinn, 2005; as cited in Morley & Tyrrell, 2023). At the university level, academic difficulties have a negative impact on student's mental health (Quinn 2005; as cited in Morley & Tyrrell, 2023). The additional pressures associated with attending university and less familial / peer support make it even more difficult for females to cope.

Comorbidities

In the 2007 National Survey of Children's Health which included children between the ages of 6 and 17 years old with ADHD; 33% had one comorbidity, 16% had two comorbidities, and 18% had three or more (Cuffe et al., 2023). The most prevalent comorbidities associated with ADHD are disruptive behavior disorders (50%) and anxiety and depressive disorders (25-30%) (Barkley, 2006, as cited in Cuffe et al., 2023). Children with ADHD are at a greater risk of being diagnosed with a comorbid condition than children without ADHD (Barkley, 2006). However, females are at a greater risk of having a comorbid disorder than males (Morley & Tyrrell, 2023). Individuals diagnosed with comorbid disorders are more likely to experience academic challenges, delinquency, parent-child communication, social competence, and parental aggravation (Counts et al., 2005; Massetti et al., 2008; Sibley et al., 2011).

Many women are diagnosed with ADHD later in life which is often a result of their symptom presentation which does not fit the stereotype associated with ADHD. An added challenge for women with ADHD is managing comorbid psychiatric conditions. The most prevalent comorbidities are anxiety and affective disorders which often continue into adulthood (Quinn & Madhoo, 2014). Women diagnosed with ADHD in adulthood are more likely to have

experienced depression and anxiety in comparison to those without ADHD (Quinn & Madhoo, 2014).

These findings highlight the additional challenges that women with ADHD are burdened with which can prolong their diagnosis and negatively impact their overall wellbeing. In addition, women with undiagnosed ADHD are often diagnosed with another mental health disorder prior to receiving an ADHD diagnosis. Many of the symptoms of ADHD are like other mental health disorders which can contribute to misdiagnosis and often results in females being prescribed medication for a different disorder.

Anxiety

Children with both anxiety and ADHD often experience severe anxiety symptoms and are more likely to have additional comorbid psychiatric disorders (Katzman et al., 2017; as cited in Dati et al., 2019). Females with ADHD between the ages of 6 and 18 have higher rates of multiple anxiety disorders and major depression in comparison to healthy controls (Siddiqui et al., 2024). Females are also more likely to have specific phobias or generalized anxiety disorder. These comorbidities may impact the timeline of receiving an ADHD diagnosis which is supported by a nationwide survey that found a larger number of girls are prescribed antidepressant medication prior to being treated for ADHD (Quinn et al., 2014, as cited in Siddiqui et al., 2024).

Bowen et al., (2008) studied the clinical characteristics of children with ADHD and comorbid anxiety disorders. This study found that 50% of children with ADHD also had an anxiety disorder (Bowen et al., 2008). Children with this comorbidity, had more anxiety and depressive symptoms, more attention problems and were less socially competent than children with only-anxiety or only-ADHD (Bowen et al., 2008). Interestingly, in this study, parents

reported that the age of onset of hyperactivity symptoms in children with ADHD and anxiety disorder was 5.2 years compared with 2.2 years of children with ADHD only. This suggests the presence of anxiety may alter the typical presentation of ADHD symptoms (Bowen et al., 2008).

Depression

Depression is a common comorbidity with ADHD, and it can create additional difficulties for treatment outcomes. Depressive symptoms can exacerbate the symptoms of ADHD and result in a greater level of dysfunction (Turgay et al., 2003). In a study by Blackman et al. (2025), researchers found that children diagnosed with both ADHD and depression were the most impaired in the social competence category. There were no differences found between the levels of aggressive behaviors in the depressed ADHD versus non-depressed ADHD group. This study found that children in both the non-depressed ADHD group and the depressed ADHD group were more impaired in social and academic functioning in comparison to the control group.

In a study by Mitchison and Njardvik (2019), researchers looked at the prevalence of comorbid disorders in children. Participants in this study were 197 children between the ages of 8 and 15 years old, 73.6% were boys and 26.4% were girls. This study found that girls reported more depressive symptoms than boys with a higher score on the *Children's Depression Inventory* (CDI) which is a self-report measure of depressive symptoms.

Women and girls with ADHD struggle more with low self-esteem than boys. In a study of adolescents between 13 and 16 years, girls reported more negative self-esteem in comparison to boys with ADHD and the controls on the Children's Depression Inventory (Quinn & Madhoo, 2014).

Interpersonal relationships

Children with ADHD often struggle to form relationships with peers and experience challenges in social settings. In a study by Kok et al., (2016), researchers found that girls with ADHD experienced more social skill deficits which were associated with lower levels of self-esteem. In addition, the impact of negative peer relationships may impact girls more than boys due to girls typically having more intimate social connections (Kok et al., 2016). Many of the behaviours associated with ADHD are regarded as more deviant when exhibited by girls rather than boys. This is likely due to societal norms and the stereotypical behaviors of ADHD which are closely associated with boys. Additionally, girls with ADHD reported having more social skill deficits which negatively impacted their self-esteem (Kok et al., 2016). In comparison to typically developing (TD) girls in this study, girls with ADHD had lower levels of social competence, general social functioning, and higher levels of social impairment (Kok et al., 2016). These findings show the extent to which peer relationships and social functioning are impaired in girls with ADHD and the negative impact it has on their overall mental health and well-being.

Quinn and Madhoo (2014) conducted a research study on girls with ADHD attending a summer camp (6-12 years). Researchers found that girls with ADHD had less friends, more difficulties within their friendships, and overall, their friendships were less stable than girls without ADHD. In a more recent study by Frick et al. (2025), females with ADHD struggled to maintain friendships due to being bullied or excluded by their peers. These negative experiences resulted in a loss of trust in others and made it even more challenging to form stable friendships.

Misdiagnosis

Another common issue that women with ADHD face is receiving a misdiagnosis. This often leads to prolonged treatment times which leads to girls managing their symptoms without adequate support and resources. Since girls typically exhibit more internalizing behaviors, their symptoms often lead to a misdiagnosis of personality disorders or other internalizing disorders due to their symptom presentation (Young et al., 2020).

Another factor that impacts the trajectory of females receiving an ADHD diagnosis is their symptoms are often misinterpreted as a different disorder or overlooked due to their symptoms being more internalizing. Fourteen percent of girls with ADHD are prescribed antidepressants in comparison to just five percent of boys (Attoe & Climie, 2023). Females with ADHD are also at a greater risk of engaging in risky sexual behaviors which can create additional stress. Females who remain undiagnosed into adulthood have increased societal expectations (parenting, household chores etc.) that can exacerbate their symptoms and make it difficult to manage without the appropriate treatment and support (Attoe & Climie, 2023).

One of the consequences of females receiving a delayed ADHD diagnosis is the prolonged period they are left to deal with their symptoms without receiving the recommended treatment specific to the disorder (Garcia-Argibay et al., 2021). From a healthcare perspective, there is a higher cost associated with treating individuals with ADHD (Garcia-Argibay et al., 2021). It would benefit both the burdened healthcare system as well as the patients to explore diagnostic methods that are tailored towards females' presenting symptoms which would allow for detecting ADHD at an earlier age.

ADHD can be detected as early as 3 years of age and early detection can help mitigate some of the negative effects of remaining undiagnosed for a longer period (Meyer et al., 2020). Some of the additional outcomes often associated with ADHD are low self-esteem, difficulties in

interpersonal relationships, delinquent behavior / substance abuse, and academic struggles to name a few (Harpin 2005; Shaw et al., 2012; as cited in Meyer et al., 2020).

In a more recent study by Morgan et al., (2023), females who received a diagnosis in adulthood reported feeling frustrated that they had to suffer silently over the years and regret missing opportunities. They also shared the negative impact it had on their self-esteem and overall mental health (Morgan et al., 2023). The impact of receiving a diagnosis later in life drastically impacts females daily functioning and can be exceedingly difficult to cope without the necessary support and resources.

Stigma

There is stigma surrounding ADHD which can negatively impact the treatment outcome of the individual. Stigma is defined by Link and Phelan (2001) as being divided into four distinct categories: labelling, stereotyping, separation, and discrimination. In a study conducted by Toye et al., (2021) researchers observed the relationship between knowledge of ADHD and stigma in education professionals. The findings from this study showed that teachers' knowledge about ADHD was related to more positive attitudes towards inclusion. Teachers with more training and experience working with children diagnosed with ADHD were better equipped to structure lessons accordingly. One of the recommendations from this research finding is to provide more extensive training to education professionals to support children with ADHD more effectively and to gain a deeper understanding of how the diagnosis impacts children's ability to participate in certain class activities (Toye et al., 2021).

Peer Relationships. Peer relationships play a crucial role in the development of children's social skills and the experience of being ostracized can have a significant negative impact on mental health and self-esteem. Mikami et al. (2022), found that children with higher

levels of social and academic competence were more likely to have a negative view about students exhibiting these behaviors in comparison to students with lower levels of social and academic competence. Researchers suggested further research to be obtained on why children with higher academic and social competencies reported higher levels of dislike for children displaying symptoms of ADHD (Mikami et al., 2022). The impact of stigma drastically impacts children's beliefs of their diagnosis as well as parents which can make it more difficult to manage and more challenging for positive treatment outcomes.

Theoretical Framework

Attachment Theory

Attachment theory was developed by John Bowlby (1969) who was a British psychiatrist and psychoanalyst. This theory posits that infants need "…a consistent nurturing relationship with one or more sensitive caregivers to develop into healthy individuals" (Bowlby, 1969, cited in van Rosmalen et al., 2016, p. 22). If a caregiver is unable to provide the infant with appropriate levels of nurturing, it can lead to infants developing insecure attachment styles which influence their development (van Rosmalen et al., 2016). In Bowlby's attachment model, children develop an internal working model (IWM) in response to how an attachment figure responds to the infant's needs and how they interact with them (Kissgen & Franke, 2016). If the caregiver exhibits competent, reliable, and predictable responses the infant will develop a secure attachment to this individual (Kissgen & Franke, 2016). However, if the infant views the responses of the caregiver as misinterpreted or unresponsive it will result in the infant developing an insecure-avoidant attachment (Kissgen & Franke, 2016).

Mary Ainsworth is also well known for her significant contributions to attachment theory, specifically through the Strange Situation Experiment. In this experiment, an infant is placed in a

room with their mother, a stranger then enters the room, the mother leaves briefly and then return to the room. The stranger then exits the room followed by the mother, while the child remains alone in the room. (Ainsworth & Waters, 1978, cited in van Rosmalen et al., 2016). The purpose of this experiment is to observe individual differences in attachment styles of infants when they are separated from their mother. If the child, after a short period of reunion crying, resumes playing with the toys and quickly calms, the child is likely to have a secure attachment style. If the child is not interacting with the mother on her return to the room, that child might be insecure avoidant. If the child cannot calm after the mother returns and remains activated for a significant amount of time, they would be termed insecure resistant/ambivalent (anxious or fearful) (van Rosmalen et al., 2016).

There are four identified attachment styles: secure, insecure avoidant, insecure ambivalent, and disorganized (Wylock et al., 2023). A secure attachment style is characterized by the ability to adapt to new situations and regulate emotions. Individuals with an avoidant attachment style struggle to identify the presence of negative emotions which results in appearing unbothered when separated from their caregiver. In contrast, an ambivalent attachment style is characterized by hyperactivation of their emotional regulation system, which leads to distress when separated from their caregiver. A disorganized attachment style often occurs in children who have experienced traumatic relationships, and it impacts their ability to regulate their emotions.

Attachment Theory and ADHD

ADHD and insecure attachment styles share some key similarities such as hyperactivity, impulsivity, and emotional regulation (Wylock et al., 2023). Research has found that children with a secure attachment style perform better in attention-related tasks and have a longer

attention span (Kissgen et al., 2016), whereas children with an insecure attachment style (avoidant or preoccupied) are more likely to experience difficulties in emotional and behavior regulation (Kissgen et al., 2016).

Previous research has found that there is a connection between ADHD and insecure attachment styles. Many of the symptoms of ADHD involve impairments in emotional regulation such as inhibition, impulse control, patience, and perseverance. These symptoms are also prevalent in individuals with an insecure attachment style which has led some researchers to view ADHD as a self-regulation disorder. In contrast, secure attachment is positively associated with cooperation, perseverance, and greater effectiveness (Franke et al., 2017). In a study by Thorell et al. (2012), after controlling for externalizing behaviors and executive functioning, a significant correlation was found between disorganized attachment style and ADHD (Franke et al., 2017).

To assess children's attachment styles in early childhood the Attachment Story Completion Task (ASCT) and the Separation Anxiety Test (SAT) are often used. In the ASCT, the child's task is to complete the beginning of stories using the attachment system with figurines. In the SAT, a child responds and describes their feelings after observing hypothetical situations of images of people being separated (Wylock et al., 2023). In a systematic review of literature studies on this topic, two studies that used a "response-to-picture" method found a relationship between ADHD and insecure or disorganized attachment (Wylock et al., 2023). The responses of children with ADHD to these images were more aggressive in comparison to typically developing children's responses.

Application of Attachment Theory

Attachment Theory will be informing the framework for the workshop outlined in the following chapter. Through an attachment theory lens, the parent-child attachment relationship will be one of the main focuses of the workshop.

Some of the challenges that many parents of children with ADHD face are responding negatively to their child, stress, exhaustion, and depression (Brown et al., 2025). Brown et al. (2025) conducted a qualitative study on parents' experiences raising children with ADHD and their feedback about a proposal for an ADHD program. Analysis of the data revealed three key themes in caregivers' experiences of raising a child with ADHD. Caregivers expressed deep love for their child while acknowledging the challenges of ADHD-related behaviors. They described ongoing struggles with compliance, behavioral control, and task completion, reflecting the demands of daily management. Additionally, caregivers reported that these responsibilities were exhausting and often accompanied by feelings of isolation, highlighting the emotional strain associated with caregiving (Brown et al., 2025).

Each of these themes provides valuable insight into the nuanced experiences that parents experience when raising a child with ADHD. Furthermore, parents' responses to the proposed parenting program improved the attachment relationship with their children. It also provided them with education about ADHD's effects of the brain and cognition (Brown et al., 2025).

While Attachment Theory emphasizes the early caregiver–child bond and its influence on individual development, Bowen Family Systems Theory expands this perspective by examining how family-wide emotional patterns and intergenerational dynamics shape behaviors and relationships across the entire family system.

Applying Bowen Family Systems Theory to Families and Children with ADHD

Families with a child who has ADHD often experience significant distress which can eventually lead to caregiver burnout (Barkley et al., 2015, as cited in Carr et al., 2020). Parents / guardians who are experiencing burnout may respond to their child less positively and may be less available to their child's needs. This can result in the child experiencing more distress and further escalating their behaviors (Carr et al., 2020). To better understand how caregiver burnout and escalating child behaviors occur within the family, Bowen Family Systems Theory provides a framework for examining the family as an interconnected emotional unit rather than a collection of isolated individuals.

Bowen Family Systems Theory (BFST) was developed by Dr. Murray Bowen and views the family as an emotional unit where each individual behavior is interpreted through the lens of family systems and intergenerational relationships rather than in isolation (Calatrava et al., 2022). BFST involves eight core concepts: differentiation of self (DoS), triangulation, family projection process, multigenerational transmission process, emotional cutoff, sibling position, nuclear family emotional process, and societal emotional process (Calatrava et al., 2022). Differentiation of self involves "…the capacity to maintain emotional objectivity amidst high levels of anxiety in a system while concurrently relating to key people in the system" (Calatrava et al. 2022, p.2). The DoS is an individual stable construct that is the result of emotional functioning in the family unit intergenerationally and within the immediate family (Calatrava et al., 2022). Triangulation is described as an emotional configuration that involves three people and are dynamic and fluid. The nuclear family emotional system refers to the emotional functioning of a family in a single generation wherein anxiety can be dispersed between family members through triangulation. The family projection project occurs when parents diagnose their child's behavior which results in their child developing through the lens of their parent's

projection (typically occurs between mother and child) (Crossno, 2011). The multigenerational transmission process is a generational process that occurs when a child who is the most impaired and has the lowest level of differentiation marries someone with a similar level of differentiation and carries on the cycle. Sibling position refers to the unique characteristics of siblings and their roles within the family that can shape their development, this concept is based on Walter Toman's research. Emotional cutoff refers to an unhealthy emotional attachment to parents which results in the inability to develop healthy emotional attachment to others. Finally, societal emotional process refers to the way in which society impacts the family system (Crossno, 2011). Understanding these family system dynamics is critical for addressing ADHD, as caregiver burnout and disrupted family interactions can exacerbate ADHD symptoms and influence the child's behavioral and emotional outcomes.

Summary and Synthesis

In this chapter, I explored relevant research on the prevalence of gender differences in ADHD diagnosis. I also highlighted the additional challenges that females face, along with the implications of females receiving a diagnosis later in life. The gender bias that is rooted in outdated research studies that primarily involved male participants shows the need for a more accurate diagnostic system that accurately represents females and their unique symptomatology. Attachment theory depicts a connection between insecure attachment style and some of the symptoms of ADHD, specifically symptoms of emotional regulation. The connection between ADHD and insecure attachment styles as illustrated by Wylock et al. (2023) shows the similarities and provides insight into using an attachment lens when treating ADHD.

Chapter 3: Discussion, Workshop and Conclusion

In the previous chapter, relevant research on gender disparities in ADHD diagnosis in females was discussed. Chapter 3 will propose an ADHD workshop for parents, families, and girls presenting with either ADHD symptoms or an ADHD diagnosis. This workshop is informed by attachment and will include a psychoeducation piece as well as tools to implement into daily life. The aim of this workshop is to address the gap in resources for girls with ADHD and educate families and parents about some of the nuances associated with symptom presentation in girls.

Workshop Outline

Workshop Title: Understanding ADHD in Girls: Through an Attachment Lens

This workshop is created for mental health professionals, families of girls with ADHD, and girls with ADHD. The goal is to provide psychoeducation about ADHD presentation in girls and provide a safe and inclusive space for families and children to feel supported and seen. The workshop will be informed by Attachment Theory, examining how early attachment styles can influence a child's development, while also adopting a holistic, family-centered approach that recognizes the importance of the family and the critical role the family system plays in the treatment process. Participants will have the opportunity to share any areas they may be experiencing difficulties in, as well as any coping mechanisms they have found to be effective.

Goals of Workshop

This workshop aims to empower girls with ADHD by helping them better understand their symptoms and to providing practical strategies for managing them. In addition, it seeks to support parents and their daughters in strengthening their relationships while deepening their understanding of Attachment Theory in the context of ADHD.

Target Audience

This workshop is designed for girls with ADHD as well as for individuals seeking guidance on how to support them.

Families

Families who have a daughter with ADHD are also a target audience for this workshop. Parents and siblings can play a critical role in the effectiveness of ADHD interventions and in fostering the self-esteem of children with ADHD. The information provided in this workshop is intended to educate and inform families on strategies to best support them.

Mental Health Professionals

This workshop is also designed to inform mental health professionals and provide them with more knowledge about the unique presentation of ADHD in females.

Considerations for Implementation

Workshop facilitators should possess a strong knowledge of the subject matter to ensure that participants receive accurate, relevant, and practical information. Given that the workshop is designed for both parents and children, it is essential that facilitators establish a safe environment and clearly communicate expectations from the outset. Furthermore, facilitators should employ a client-centered approach that is culturally responsive and promotes inclusivity for all participants.

Ethical Considerations

Ethical considerations for this workshop are to ensure that participants are aware of the limits of confidentiality as well as maintaining confidentiality within the group itself. Clients' privacy and confidentiality will be protected and group members will be expected to maintain confidentiality of other members within the group. Facilitators will review limits of

confidentiality which is a legal obligation all counsellors must uphold as is outlined in the BCACC Standards of Ethical Practice.

1. There is a substantial risk of serious imminent harm being inflicted by the client on themselves.
2. There is a substantial risk of serious imminent harm being inflicted by the client on another
3. There is a need to protect an identifiable minor or vulnerable adult consistent with applicable law
4. It is in accordance with any other lawful requirement to do so, such as a court subpoena (BCACC, 2023)

The facilitator(s) must ensure they are aware of any transference / countertransference that may arise during the group and seek out supervision when necessary to ensure they are not negatively impacting the group dynamics. Countertransference was first recognized by Sigmund Freud in 1909 and is a counsellor's feelings or emotions that arise in response to a client (Prasko et al., 2022). It is likely that countertransference will occur, but it is the counsellor's responsibility to ensure they engage in self-reflection and supervision to address their unresolved emotions (Prasko et al., 2022). Transference is a client's response to a counsellor based on their previous experiences or relationships with other individuals (Prasko et al., 2022). Additionally, facilitators must prioritize creating safety within the group to ensure that all participants feel comfortable to share openly and remain within their window of tolerance. Finally, facilitators must ensure they are adhering to the ethical code relevant to their jurisdiction, for example the British Columbia Association of Clinical Counsellors (BCACC).

Recruitment

To promote accessibility for individuals across diverse demographic groups, facilitators should share information about the group across multiple settings such as elementary schools, church groups, mental health clinics, paediatricians, recreation centres, and women's shelters. The purpose of the group is to reach individuals from various socio-economic backgrounds and to not be exclusionary. In creating the group, facilitators will limit the number of participants per group to ensure the highest level of care is given to each participant.

Informed Consent

Informed consent is an important aspect of any type of therapy, and it is a priority to ensure that participants are aware of what their participation will include. For this workshop, participants will be emailed an outline of the group prior to the group commencing. On the first session, facilitators will review informed consent with participants and allow for a question period. Since there are children involved in this group, it is important to ensure that informed consent is provided at their developmental level and is understood fully.

Duration of the Group

A typical duration for time-limited group ranges between 6 to 12 sessions depending on the specific nature of the group and each session is usually 90 to 120 minutes. This workshop will occur for 8 consecutive weeks with each session being 90 minutes in length. The designated duration is intended to provide participants with sufficient opportunity to contribute while accommodating individuals who may require additional time to feel comfortable within the group setting.

Session Outline

This workshop is divided into six sessions wherein each session will incorporate some psychoeducation about ADHD and attachment theory. Each session will provide participants the

opportunity to share feedback regarding its effectiveness, as well as any concerns or emotions that arose during the section. Refer to Appendix A for a more in-depth overview of the sessions.

Session One: Psychoeducation on ADHD origins

The initial session will primarily involve building rapport with participants and creating safety within the group setting. Group goals and expectations will be discussed to ensure that all participants are aware of their responsibilities throughout the group duration. After addressing these matters, facilitators will share some brief psychoeducation about the origins and history of ADHD as well as provide some examples of the symptom differences between boys and girls. At the end of the session, participants will have the opportunity to ask questions, and the group will end with a check-in about their experience. The following information will be presented to participants in the group session.

George Frederic Still, a pediatrician practicing in London during the early 19th century, is widely recognized for his pioneering contributions to the study of ADHD (Martinez, 2015). Despite his early research, ADHD was not formally classified as a disorder in the DSM until 1980 (Martinez, 2015). Although a substantial body of research has since examined individuals with ADHD, the disorder remains relatively recent in formal recognition and continues to be widely misunderstood, particularly in females.

Girls are often diagnosed in adolescence or adulthood due to presenting more internalizing symptoms as opposed to externalizing symptoms which are more prevalent in boys (Klefsjo et al., 2020). In addition, most research studies on ADHD in children involve male participants which has further added to the limited knowledge about its presentation in females which can have a negative impact on their overall wellbeing and the trajectory of the disorder (Klefsjo et al., 2020).

Session Two: Introducing an Attachment Theory Lens

In the second session, facilitators will introduce Attachment Theory and discuss how it can inform the relationship between parents and children. Facilitators will share the "Strange Situation Experiment" video clip with the group and use it as a tool for discussion within the group. The following information will be presented to participants in the group session.

Attachment theory was initially developed by British psychiatrist and psychoanalyst John Bowlby (1969). In this attachment model, children are believed to develop an Internal Working Model (IWM) that impacts how they respond to their parents / caregivers (Kissgen & Franke, 2016). Children may develop different attachment styles based on their interactions with the attachment figures in their lives. There are three main types of attachment styles: secure, insecure-avoidant, and insecure-ambivalent, and disorganized (Wylock et al., 2023).

Mary Ainsworth also made significant contributions to the development of attachment theory, most notably through the "Strange Situation Experiment". This experiment involves an infant being left in a room with a stranger while the mother leaves the room. Researchers observe the infant's behavior upon being separated from their mother and then upon reunification.

The purpose of this session will be to help participants understand Attachment Theory and its relevance to parent–child relationships, using the "Strange Situation Experiment" as a practical tool to illustrate different attachment styles and foster discussion.

Session Three: Self-reflection

In this session which marks the midway point of the group, the group dynamics should be relatively defined, and participants should feel more comfortable within the group. The goal of this session is for children to reflect on their ADHD symptoms, share their experiences with their parents, and engage in a discussion to enhance understanding of their behaviors. In addition,

once each child and parent has had the opportunity to discuss the group will come together and share in the larger setting. This exercise will likely create a sense of togetherness and help the children to feel less isolated with their symptoms.

Session Four: Journalling exercise

This session will involve facilitators providing participants with a journalling prompt (adaptation: can be a drawing, painting, poem) of how they view ADHD. The purpose of this exercise is to allow children to express themselves and have the opportunity for self-reflection. Once they completethe exercise, they will share it with their parents and have a discussion with them about it. This exercise is designed to encourage relationship building between parents and their child through sharing and active listening.

Session Five: Understanding emotional regulation

Emotion dysregulation (ED) is often associated with ADHD and results in individuals displaying inappropriate behavioral responses as well as difficulties engaging in self-soothing behaviors (Barkley, 2010, as cited in Bunford et al., 2018). In this session, the focus will be for the children to share their emotions with their parents. At the beginning of the session, each child will be provided with a selection of 10 common emotions to choose from. Emotion Charades is a game that teaches children how to recognize emotions in themselves and others by acting out emotions and guessing emotions that others are acting out (Malouff et al., 2007). This activity is designed for children 5 years and above and will be explained and demonstrated by facilitators prior to commencing.

Emotions will be written down accompanied with an image of the emotion on a card. Facilitators will go around the group and ask the child to select the card at the top of the pile.

The child / parent will have time to practice how they would like to act out the emotion (~2 mins). Each child will have the opportunity to act out an emotion.

At the end of the activity, there will be a debrief to review how the activity went for everyone.

Session Six: Goodbyes and Reflections

Endings can be challenging for many individuals, so facilitators should provide ample time for participants to have the opportunity to say goodbye. The goal for this final session is to give space to participants for closure and to celebrate the accomplishments of the group and everyone. Facilitators are encouraged to paint a word on a rock that reflects the growth of each participant in the group. This can positively contribute to endings and can provide participants with a physical object to remember the group by.

Limitations of this Capstone

One of the prominent limitations to this topic is the unequal representation of females in samples of research studies (Klefsjo et al., 2021) This has resulted in biases within the ADHD diagnostic and treatment planning as well as information being released that may not fully encapsulate the experiences of females presenting with ADHD symptoms. This makes it challenging to fully comprehend the nature of ADHD in females and fails to advocate for the experiences of females. There is a need for further research to be conducted that includes samples with females to reduce the stigma, educate healthcare professionals / parents / teachers, and create a tailored approach to treatment for females with ADHD.

Capstone Summary and Conclusions

ADHD is widely under researched and misunderstood in females. In recent years, increased awareness and discussions have evolved about ADHD in females, however, it is evident there is a significant way to go still. The symptom differences between males and

females play a prominent role in the diagnostic outcome. Since girls typically present with internalizing symptoms they are often overlooked and are left to manage their symptoms in isolation until they reach adolescence or adulthood.

In conclusion, this capstone has provided insights into the gender disparities that exist in ADHD and have highlighted the areas for future research and raised awareness about the lack of support for females with ADHD.

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Appendix A

According to the DSM-the diagnostic criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) are as follows:

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

1. Inattention: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

a. Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).

b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

c. Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

d. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).

e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools,

wallets, keys, paperwork, eyeglasses, mobile telephones).

h. Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Hyperactivity and impulsivity: Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

a. Often fidgets with or taps hands or feet or squirms in seat.

b. Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).

c. Often runs about or climbs in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)

d. Often unable to play or engage in leisure activities quietly.

e. Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

f. Often talks excessively.

g. Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

h. Often has difficulty waiting his or her turn (e.g., while waiting in line).

i. Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may

start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

Specify whether:

(F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

(F90.0) Predominantly inattentive presentation: If Criterion A1 is met but Criterion A2 is not met for the past 6 months.

(F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 is met and Criterion A1 is not met for the past 6 months.

(American Psychiatric Association, 2013, pp. 59–60)