

‘The Picture Between Home and School is Miles Apart’: Reflections of Parents/Carers and Professionals in the UK on the Manifestation of Attention Deficit Hyperactivity Disorder in Girls

Neurodiversity
Volume 4: 1–11
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DOI: 10.1177/27546330261487214
journals.sagepub.com/home/ndy



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Abstract

Background: Attention deficit hyperactivity disorder (ADHD) is more commonly missed in females than males, partly because the diagnostic criteria may not fully capture the female presentation. This study aimed to qualitatively identify difficulties experienced by females with ADHD, especially those beyond the current diagnostic criteria, from the perspective of parents/carers and professionals.

Method: Seven focus groups were conducted in the UK in 2023: three with parents/carers, two with healthcare professionals, and two with educational professionals, involving a total of 35 individuals. Participants were asked to describe their experiences of supporting girls with ADHD. Data were analysed using the framework method.

Results: Four themes were identified: (1) attention regulation difficulties and their social impact, (2) hyperactivity and impulsivity manifest more verbally and subtly, (3) prominent difficulties with emotional impulsivity and regulation and (4) difficulties are more obvious at home than at school.

Conclusion: Female ADHD might be missed as difficulties are less externally disruptive and more emotional than the current ADHD diagnostic criteria. Additionally, females may engage in masking behaviours. Improving current ADHD diagnostic assessments and criteria to reflect this presentation would benefit diagnostic inequalities and access to care for females with ADHD.

Keywords

ADHD, school-age children, diagnosis, qualitative research, parents/caregivers, healthcare, education

Received: May 6, 2026; accepted: August 12, 2026

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Background

Attention deficit hyperactivity disorder (ADHD) is a highly impairing neurodevelopmental condition associated with mental health problems and negative social outcomes (e.g., low educational attainment and relationship problems) (French et al., 2024). Early identification is important as it enables individuals to access support (Shaw et al., 2012).

ADHD is more commonly diagnosed in males than females during childhood (Faraone et al., 2015; Willcutt, 2012), with males almost four times more likely to receive a diagnosis than females (McKechnie et al., 2023). Further, ADHD is likely to be diagnosed, on average, later in females than males or even missed entirely (Martin, 2024; Quinn & Madhoo, 2014; Young et al., 2020). There are a variety of potential reasons for delayed diagnosis in females, including sex differences in the manifestation of symptoms (Quinn & Madhoo, 2014; Young et al., 2020). A meta-analysis reported that in children with ADHD, males expressed more hyperactive symptoms than females, with no sex differences in inattentive or impulsive symptoms (Loyer Carbonneau et al., 2021). A systematic review of item-level ADHD symptoms found that parents were more likely to endorse several inattentive symptoms in females than males with ADHD, while parents of males were more likely to endorse all the hyperactive-impulsive symptoms, except for ‘talks excessively’ (Williams, Horstmann et al., 2025). More research is needed to examine sex differences in individual ADHD symptoms.

The ADHD diagnostic criteria (e.g., Diagnostic and Statistical Manual of Mental Disorders [DSM] IV and 5) were developed using majority male samples (Clarke et al., 2013; Lahey et al., 1994). As such, the diagnostic criteria may be biased towards the male manifestation of ADHD and not fully capture the female presentation of ADHD, which may include more internal (e.g., daydreaming) or socially oriented presentations (Ohan & Johnston, 2005; Young et al., 2020). This means that females are less likely to meet the diagnostic criteria than males (Willcutt, 2012) and are underdiagnosed or receive a delayed diagnosis (Martin et al., 2026).

In-depth qualitative research is required to better understand the female ADHD presentation and identify more gender-diverse presentations, including symptoms that may not be well characterised by existing diagnostic criteria. Qualitative research findings may aid earlier recognition and diagnosis of ADHD, especially in females.

Parents/carers play a key role in identifying children’s ADHD-related difficulties and seeking support on their behalf. Educational professionals (e.g., teachers, learning support assistants) are also well placed to identify if young people are struggling academically or socially (Russell et al., 2016) and play an important role in the ADHD referral process (Sayal, 2006; Sayal et al., 2006). Along with healthcare professionals involved in referral and assessment

(e.g., GPs, psychiatrists), these groups have a wealth of experience of how ADHD manifests and impacts children. Our recent qualitative study has considered how ADHD symptoms may present in females in childhood, from the perspective of young women and non-binary adults with ADHD (Williams, Barclay et al., 2025). However, few qualitative studies have considered the perspective of parents/carers or professionals regarding how the presentation of ADHD symptoms in young girls might differ from existing diagnostic criteria.

One mixed-methods study aimed to characterise ‘female-sensitive’ ADHD behaviours (Ohan & Johnston, 2005) by reviewing previous research, interviewing mothers of girls with ADHD (aged 8–16 years), and analysing videotapes of interactions between mothers and daughters with ADHD. The authors described a list of eight female-sensitive ADHD behaviours. These behaviours were generally more socially oriented than the behaviours described in the DSM-IV criteria, including behaviours such as ‘forgetful in social activities’, ‘giggles excessively’ and ‘changes friends impulsively or without thinking’. The authors also reported that these ‘female-sensitive’ behaviours were associated with impact in girls with ADHD.

Another study aimed to identify characteristics of girls with ADHD by developing a list of 44 descriptors, using behaviours mentioned in previous research and via focus groups with women (aged 27–57 years) diagnosed with ADHD in adulthood (Grskovic & Zentall, 2010). The results found that when comparing girls with ADHD to those without ADHD, those with ADHD were characterised as more verbally impulsive and hyperactive, faster in conversations and schoolwork, more easily bored, more often stirring up trouble, having difficulty waiting, and demonstrating greater moodiness/anger/stubbornness. However, neither of these studies of female ADHD incorporated qualitative analysis, and the methodology is unclear for how the lists of symptoms were created. Further detailed qualitative work is needed to better understand the manifestation of ADHD in females.

The Current Study

The aim of this study was to characterise key clinical features of ADHD in females that parents/carers and teachers should look out for that are relevant to ADHD but may go beyond current symptom descriptions in existing ADHD diagnostic criteria, to help identify ADHD in a timely manner in primary school children.

Method

Participants

Participants included parents/carers of girls or gender non-conforming children and young people (ages 5–18) with a

diagnosis of ADHD, and healthcare and educational professionals with at least 5 years of experience of working with young people with ADHD, particularly females. Eligible participants were those who lived in the UK. The study was approved by Cardiff University School of Medicine Research Ethics Committee (SMREC 23/28).

Recruitment

Participants were recruited through online advertisement by the National Centre for Mental Health (NCMH), social media, and invitations to prospective participants by the ADHD Foundation, a UK Charity. Interested participants were directed to a website including the Participant Information Sheet, a screening questionnaire and a brief consent to contact form. The screening questionnaire to assess eligibility in parents/carers included questions on whether their child has ADHD, their current age, age at ADHD diagnosis, biological sex and gender identity. Professionals were asked questions regarding their job title, years of experience and age groups of young people with ADHD they have worked with. We attempted to mitigate non-genuine participants by looking out for participant sign-ups that had mismatched details (e.g., different name from that in their email address) and multiple sign-ups in succession, during the UK night, with a generic email configuration (e.g., name.surname11@gmail.com).

Eligible participants were contacted to schedule a focus group with others in the same group (e.g., parents/carers, healthcare professionals or educational professionals). Focus groups were held online using Zoom videoconferencing. Before each focus group, participants were emailed the Participant Information Sheet, the topic guide and a link to the online consent form. Participants provided written informed consent before taking part. Participants received a £25 thank-you voucher and childcare expenses (if applicable).

Development of Study Materials

Prior to data collection, a Youth Advisory Group of young people (ages 14–25) with lived experience of ADHD or other neurodevelopmental conditions, recruited via the NCMH, were consulted about the study materials (i.e., information sheet, consent form and topic guide), which were refined based on their input. Consultation with young people with lived experience helped ensure that the study materials and terminology used were appropriate to the experience of the population the research aimed to understand.

Focus Groups. Semi-structured discussions used open-ended questions to elicit detailed and in-depth descriptions, guided by a topic schedule (see Supplemental Materials). The topic schedules were largely similar for each group, with

questions asked within the context of each group and additional questions tailored to each group. Additional prompting questions were used if needed. Participants were asked questions based on three general topics: gender differences in ADHD, ADHD symptoms in girls and masking behaviours. Healthcare professionals were asked additional questions regarding the development of a new ADHD assessment tool. Participants were asked to focus on providing examples of difficulties they have observed in girls during primary school (ages 5–12).

For the questions on ADHD symptoms, participants were asked to reflect on lists of potential behaviours presented on slides, including the existing diagnostic criteria and 12 previously proposed ‘female-sensitive’ ADHD items (Grskovic & Zentall, 2010; Ohan & Johnston, 2005) (see Supplemental Materials). Focus group discussions were led by a psychology research assistant (TW) and a senior research fellow (JM), both trained in qualitative methodologies and both identifying as women. Focus groups were video and audio recorded. Audio recordings were transcribed verbatim by a professional transcription service and anonymised.

Analysis

The research team includes neurodivergent and neurotypical members, with a range of experiences, including clinical and non-clinical academic researchers. We used the framework analysis method, which is a codebook approach to thematic analysis that involves five nonlinear stages (Parkinson et al., 2016). For a detailed description and justification of use, see Williams, Barclay et al. (2025).

Focus group transcripts were coded line by line (open coding) using NVivo version-12. The first author (TW) coded all seven transcripts (100%), consulting regularly with the senior author (JM) to discuss the codes, refine the analytic framework and generate the themes.

Results

Seven focus groups were held: three with parents/carers, two with healthcare professionals and two with educational professionals, with 35 participants in total. Sixteen participated in the parent/carer groups (1 male and 15 females), and all had experience of at least one child (aged 7–16) assigned female at birth diagnosed with ADHD; 15 identified as girls and one as non-binary. The average age at diagnosis was 9.4 years (see Table 1). Eleven participated in the healthcare professionals’ group and eight in the educational professionals’ group. A range of professionals participated, including, but not limited to, a consultant child and adolescent psychiatrist, senior mental health nurse, special educational needs coordinator and special educational needs teacher. Most professionals ($n = 15$) reported experience of working with children during primary school (aged 5–

Table 1. Focus Group Length and Participant Descriptives.

	<i>M</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>
Amount of experience, years (professionals only)	11.92	6.63	5	24
Child's age at diagnosis, years (parents/carers only)	9.40	3.22	5	16

12), while the remaining participants primarily worked with young people aged 12 onwards. The professionals had an average of 11.9 years of experience (see Table 1).

Focus groups lasted between 51 and 86 min ($M = 74.74$ min, $SD = 10.47$ min).

There was some overlap in group categories. One parent/carer mentioned they were also a professional, four professionals (two educational and two healthcare) mentioned having children with ADHD, and four educational professionals mentioned they had an ADHD diagnosis.

Analysis

Four themes were identified: (1) attention regulation difficulties and their social impact, (2) hyperactivity and impulsivity manifest more verbally and subtly, (3) prominent difficulties with emotional impulsivity and regulation and (4) difficulties more obvious at home than at school. Each theme is discussed below, with selected quotes to illustrate key concepts.

Theme 1: Attention Regulation Difficulties and Their Social Impact

There was strong agreement across participant groups that girls with ADHD present with prominent attention regulation difficulties, which is a key dimension of ADHD.

A phrase that seems to come up repeatedly is, "Off with the fairies", which seems to [...] encapsulate [...] the general presentation of the primary school age girls. (Healthcare professional [HP])

The difficulties described by participants included all inattentive symptoms in the current diagnostic criteria. As these symptoms are well-established, the analysis and quotes below focus on relevant examples from participants, which go beyond the wording of ADHD diagnostic criteria. These include behaviours such as daydreaming, losing track of their own thoughts during a conversation, doodling during a lesson instead of paying attention, quickly switching between hobbies/activities as they become bored easily, being forgetful in social situations and hyper-focusing on people or activities they find interesting.

When she loses her concentration, it just looks like she's day-dreaming. (Parent/carer [P/C])

I had a bit of a fight with school, because they were saying [...] she won't focus [...] she's always drawing on her hands [...] she's constantly doodling, or she's messing with a ruler. (P/C)

I agree with the forgetfulness. Not just with the schoolwork, generally forgetful. Appointments [...]. As well as kind of a tendency to be late, in general. (HP)

I think that my daughter's got an ability to hyperfocus. So, when she's really interested in something, that's it. She's like dead to the world. (P/C)

Notably, some participants reported that girls' attention regulation difficulties can be more pronounced when they are 'bored' or do not find something fun or engaging.

I think there's a big thing around being bored and not being able to pay attention when something is deemed as boring. (Educational professional [EP])

I think interest [...] and hobby switches is something that we see so much [...] when we explore that with the young person, they're like, well, I'm bored of that one now. (HP)

Participants discussed masking and compensatory strategies that girls with ADHD used but noted that these were rarely effective. Examples of masking and compensatory strategies included making their work neat and pretty, appearing as if they are paying attention (e.g., nodding along) or using lists/diaries.

I call them the gel pen girls [...] who will make everything look so beautiful and well-presented [...] But they won't actually have listened to any of the content. (EP)

She can lose her concentration, even just when the instructions are being given. She'll nod along like everyone else, but [...] it hasn't gone through what she's been told. (P/C)

Some [...] enjoy having a physical diary, but then, might lose the diary. (EP)

Overall, participants mentioned that inattentive behaviours are difficult or even impossible to mask/compensate for.

When it comes to sitting still, or paying attention, or doing a simple sum, or interacting in that conformed way, she literally can't. (P/C)

All participant groups mentioned that girls with ADHD may be underdiagnosed as they present differently than boys. Participants reported that ADHD behaviours of girls may be less external and disruptive to others, and inattentive behaviours may be viewed as more acceptable.

Many don't get detected because they don't score highly on particularly the Connor's or SNAPs [...] which are much more kind of outward behavioural screeners. I think also, generally, there's a perception of girls being quiet and kind of well behaved, and usually the presentation of ADHD is around inattention with the girls. (HP)

She was always just labelled as [...] a social butterfly. She always wants to talk to people. She's got loads of friends, and she flits from place to place. Which in the really early years of primary was [...] always sort of brushed under the table [...]. Them behaviours had almost been egged on, because it was so nice, and it was so cute. (P/C)

Although inattentive behaviours may not be disruptive, they can still have a marked impact. This especially includes social impact, where inattentive behaviours (such as forgetfulness or not listening to others speaking) can negatively impact friendships. There can also be a negative impact at school, as not listening can get them into trouble.

Forgetting to contact people in her social circle and sort of wanting that sort of social activity but not remembering to do your part to build that friendship. (P/C)

Both at school but also at home, because of the inattention and her tendency to wander off [...] so I think have to sit and police it, and [...] it just drives me nuts. (P/C)

Typically, a girl will be inattentive. So, if they're not attentive then they're not listening. So then, they would be more likely then to thought to be not behaving, or not co-operative in the classroom. [...] That causes a lot of distress for the parents and carers and the child themselves, because they're labelled as not behaving, or not fitting in with [...] classroom rules, or the school rules. (HP)

Theme 2: Hyperactivity and Impulsivity Manifest More Verbally and Subtly

Unsurprisingly, all participant groups mentioned hyperactive-impulsive behaviours in the ADHD diagnostic

criteria. All groups stressed that hyperactivity/impulsivity in girls may present more verbally than as physically disruptive behaviours (e.g., talking excessively, blurting out answers, interrupting others). Participants also mentioned that girls often say things before thinking them through and can impulsively change conversation topics, which are not strictly in the diagnostic criteria.

The hyper-ness in girls are often coming out on the speech and language side as excessive chattiness. So, rather than excessive movement and fidgeting. (EP)

My daughter has a tendency to say what she thinks when she thinks it, and it may not be the nicest of things to say [...] and that can cause upset for [...] other children, and occasionally a staff member. (P/C)

If she's done with a conversation, if it's not interesting her anymore, she will very quickly just change it to something that she does want to talk about, that's going to interest her. (P/C)

Participants also mentioned that hyperactive-impulsive symptoms may be more subtle or less disruptive than descriptions in diagnostic criteria (e.g., subtle fidgeting with pens, biting nails and skin picking). Hyperactivity may also be internalised (e.g., inner restlessness, overthinking and racing thoughts).

Their hyperactivity is often more subtle in terms of fiddling with things, [...] chewing their nails, [...] pulling apart a pen [...]. So, there seems to be more... less big, obvious physical activity I think in girls. (EP)

That inner restlessness, [...] we call it a busy brain for the younger ones. (HP)

Participants mentioned that hyperactive-impulsive behaviours appeared to be masked from an early age. Masking behaviours included attempting to restrain themselves from fidgeting or fidgeting in a less noticeable manner (e.g., using fidget toys and doodling), trying to be quiet so as to not annoy others and also finding socially acceptable reasons for movement breaks.

So, fidgeting. But that was relieved through doodling, and [...] things like Blu Tack and fidgeting toys. (P/C)

I mean, for my child, it's the talking excessively. But that is something that she now realises that other people find really irritating [...] she just is now mute, because she realises that's why she's disliked. (P/C)

Going to the toilet repeatedly during a lesson just to... because you don't necessarily have the language, or the awareness at that point, to know that you need a wriggle break. (EP)

The motivation for masking often stemmed from girls' wanting to fit in with others or avoid getting in trouble.

They want to [...] appear the same as their peers. (P/C)

She doesn't want to get into trouble. She's terrified of getting a dot, which is a system the school uses if they do anything wrong, and so, she's trying hard not to do that. (P/C)

Although hyperactive-impulsive behaviours may be relatively physically subtle and more verbal, they still have a significant impact, especially socially. These behaviours can also get girls into trouble at school or out-of-school clubs.

That blurting [...] can be really common and alienating because your friends think you're not listening to them, and you don't value them. When actually, you're trying to empathise. (EP)

My daughter would [...] constantly get told off for shouting out, but [...] if she has an idea, she has to get it out. She can't hold it, [...] and say it later, because she forgets. (P/C)

Verbally hyperactive/impulsive behaviours were also mentioned as impactful on an individual's self-esteem and mental health. Additionally, internalised hyperactivity was reported as disruptive to sleep.

A lot of the girls [...] feel really ashamed, because they know they've done something wrong but they couldn't help themselves, and examples are simple things like blurting things out, you know, shouting out, interrupting people. (EP)

She doesn't sleep very well. It's like a constant circle of being exhausted in school because she's trying to adapt to the school, and then, coming home, and [...] not having the time to rest because it is a constant circle of thought processes and actions, and there's no rest for her. (P/C)

Theme 3: Prominent Difficulties With Emotional Impulsivity and Regulation

All participant groups reported that girls with ADHD have substantial difficulties with emotional impulsivity and regulation, including emotional outbursts/meltdowns, intense emotional reactions, being quick to anger, and being sensitive to rejection.

I feel like the girls that I've worked with in primary school are emotional timebombs. (EP)

She gets home, and the slightest issue, she'll just completely meltdown, and it's really, really intense. It seems to me like

an over-reaction. But obviously, it's not to her. [...] And she takes a really long time to come down from that. (P/C)

Anger is probably our worst one. She gets very angry very, very quickly. [...] I kind of relate it to, you know, shaking a coke bottle and then releasing the lid. (P/C)

For many I work with, that's the most disabling aspect of ADHD is constantly being hypervigilant to criticism or rejection that may not exist. (EP)

Emotional dysregulation problems also have a profound impact for girls with ADHD, leading to difficulties with friendships and family members.

My daughter has a phenomenal temper and can anger very quickly and lash out, especially at her brother and me. So [...] because she's struggling to regulate, you know, she can cut deep with her words. (P/C)

All her peers, again, were kind of like she [...] always cries. She always [...] gets stroppy, and cross. (EP)

Participants also mentioned that girls with ADHD often experience shame and regret after having emotional 'meltdowns'.

The biggest challenge there is when the girl [...] calms, they're then hit by a wave of shame, [...] which is probably harder than the meltdown itself for them. (EP)

Healthcare professionals mentioned that emotional dysregulation often drives referrals to services for girls with ADHD, as it can be challenging for parents/carers and teachers to manage.

I guess this is the bread and butter of what we see, [...] people coming from crisis team, emotional dysregulation. (HP)

Her emotional response is so intense [...] and it's the hardest thing for us, as her parents, to try and support her through. (P/C)

Additionally, healthcare professionals reported frustration at emotion dysregulation not being included in the ADHD diagnostic criteria.

I'm always frustrated [what] isn't here is kind [...] the emotional dysregulation side of things, because that... there's a high level of that within girls [...] is quite important to have as part of the criteria [...] I'm always so mindful that might be interpreted as being a separate thing. But actually, it comes part and parcel of the product of some of these difficulties they have. (HP)

Theme 4: Difficulties are More Obvious at Home Than at School

A common issue mentioned repeatedly was that difficulties and ADHD-related symptoms in girls were often more pronounced at home and places where they feel comfortable (e.g., outside school clubs) than at school.

The picture between home and school is miles apart. (HP)

Participants, especially parents/carers, reported that during school, girls with ADHD often appear quiet, shy and introverted, trying their best to do what is expected of them, giving the appearance that they are 'fine'. However, when girls with ADHD return home from school, they are different, often having emotional meltdowns/outbursts, and being extremely talkative.

I think in school, my child would be seen as a very quiet, shy, reserved, studious child. And at home, she's a very loud, doesn't stop talking so, like completely polar opposite to what is seen in school. (P/C)

One of the challenges I've experienced, both professionally and personally, is that my daughter doesn't present in the same way in the school environment. We then have massive meltdowns when she returns home [...] and comes home into her safe space. (EP)

Participants suggested that these differences between home and school may be due to masking.

I guess it must be the masking all day at school, and holding everything in. Because her teachers don't see any issues [...] so, she gets home, and the slightest issue, she'll just completely meltdown. (P/C)

The girls kind of manage, go under the radar, they are quiet. They might be gone with the fairies, but no-one tends to notice, because they don't cause any problems. (HP)

Additionally, participants mentioned masking can be done successfully by young people at school, to the point where they may not appear to be struggling.

Quite often they are masking at school, and they're behaving really well so it comes as no concerns on one [ADHD] screener. (HP)

My daughter is an absolute professional at masking and repeatedly raising it with her school didn't gain any support or assistance for me because she can mimic social cues and [...] hide all of her symptoms really well. (P/C)

Girls may mask symptoms during school, as it is not an environment in which some children feel comfortable. In contrast, they may feel comfortable enough not to mask at home and in other places (e.g., relatives' homes or clubs).

You can tell she's trying to contain everything until she's in a space where she feels it's a safe outlet, whether it's at a member of staff, or home, where she feels like she can change how she behaves, or how she responds to things. (P/C)

We then have massive meltdowns when she returns home, [...] she's trying to process the friendships issues, the navigating of the sensory overload, and comes home into her safe space. (EP)

Participants mentioned that when seeking an ADHD diagnosis, some used environments outside the traditionally examined home and school environments (e.g., clubs such as Guides), as some girls with ADHD do not display many, or any, symptoms or impairment at school.

The criteria [NICE] is two or more environments where these behaviours are being shown. In my area [...] it's got to be school and home. [...] I think that it's really important that we start to think about that in regards to the masking. Because the masking can be done so well by these young people [...] that it's not being seen at school. They're coming home, [...] perhaps they might be going to clubs or to other family [...] where these behaviours are being seen to a degree. (HP)

We used a report from Guides as supplementary evidence for my daughter because there was very little in her school report [...] maybe they need to see evidence as a matter of fact from more points of reference. (P/C)

Scaffolding and support from others were also mentioned as reasons girls may not be recognised as having ADHD in primary school. Parents/carers provide support for children during primary school, which may buffer or reduce ADHD symptoms or impairment. Examples included parents/carers practising social conversations, arranging compatible playdates and packing their schoolbag or lunch box past the age at which it is typical.

I think often it gets missed, as well, how much scaffolding we do, as parents, at home. How much we are constantly on top of things to just support them, to encourage them, to remind them of things. (P/C)

We actually talk about it [...]. We can have quite open dialogue and actively discuss strategies to help her get through social scenarios, so helping her to be prepared. (P/C)

Parents kind of end up scaffolding a fair bit as well. [...] Making playdates much more shorter, you know, identifying [...] friends that can kind of tolerate the levels of energy, or kind of the way the young person is. (HP)

Their mum is packing their schoolbag for them at a stage beyond which you would think was appropriate. (HP)

Additionally, participants noted that transition periods (e.g., primary to secondary school) can exacerbate difficulties. As girls grow up, they have more demands and expectations placed on them, which they may find difficult to manage and may also find that their masking or compensatory strategies no longer work. Further, girls with ADHD may be masking their symptoms at secondary school but experience lots of difficulties as their strategies may not be very effective.

The girls kind of manage, go under the radar, they are quiet [...] they don't cause any problems. That's probably why we tend to pick them up a lot later on in life, when the expectations increase, the demands increase, and they are more aware of their own difficulty. (HP)

I think at primary school, she managed much better [...] because at primary school most of the sort of organisation is... [...] done by sort of me [...]. But as she went to her secondary school, she would walk out the door like Buckaroo. At the last minute, literally shoes in hand, nothing in her bag, grasping everything because her time management was and is non-existent. (P/C)

Discussion

This qualitative study of focus groups with parents/carers and professionals aimed to characterise the key clinical features of female ADHD that parents/carers and professionals recognised and should look out for, to help identify ADHD in a timely manner in primary school children, especially girls. We identified four themes which suggest that, in addition to current diagnostic criteria, females with ADHD may experience symptoms that are less externally disruptive and other related difficulties. Based on our study results, female ADHD includes (1) prominent and socially impactful attention regulation difficulties (e.g., losing track of thoughts), (2) more subtle and verbal hyperactivity/impulsivity (e.g., frequently changing conversation topic), (3) emotional regulation difficulties (e.g., meltdowns) and (4) experiencing more symptoms and difficulties at home (or a safe environment) than at school, partly due to masking. These difficulties may be important clinical features of ADHD to look out for in females. Further, participants reported that behaviours not strictly part of the diagnostic criteria (i.e., emotional impulsivity, verbal hyperactivity/impulsivity) that are experienced by females with ADHD cause

significant impact, especially socially. Our findings suggest that females with ADHD may present with more inattentive behaviours, as is already well established in the literature (Quinn & Madhoo, 2014; Williams, Barclay et al., 2025). Given that inattentive behaviours are less likely to be disruptive to others in class or the workplace (Quinn & Wigal, 2004), females with ADHD may be less likely to be noticed as having ADHD and therefore referred for assessment (Quinn & Madhoo, 2014). Further, our results suggest that symptoms of female ADHD may be socially oriented, including being forgetful in social situations and demonstrating verbal hyperactivity/impulsivity. Participants highlighted that ADHD in females could impact social functioning, with attention regulation difficulties having an especially large social impact. Our finding of social impact is consistent with previous studies that have attempted to characterise ADHD in girls (Grskovic & Zentall, 2010; Ohan & Johnston, 2005), which included examples consistent with those reported by our participants.

Difficulties regulating emotions and emotional impulsivity were highlighted as especially important by all groups of participants. It is clear that parents/carers and professionals who support females with ADHD consider emotional impulsivity to be highly relevant to female ADHD. Clinical practice should take these difficulties into consideration when assessing ADHD in females. Further, healthcare professionals reported that emotional difficulties drive ADHD referrals for females and could be a core feature of ADHD, despite not being part of the ADHD diagnostic criteria. These findings support previous research, which suggests emotional meltdowns and emotional lability may trigger referral of female ADHD for assessment (Young et al., 2020). Additionally, prior qualitative studies have found that individuals with ADHD, especially females, report experiencing emotional dysregulation (Ginapp et al., 2023; Schreuer & Dorot, 2017). These emotional difficulties may not be due to comorbid conditions (e.g., anxiety or depression) and may instead be intrinsic to ADHD (Skirrow & Asherson, 2013). Additionally, these emotional difficulties are associated with impairment beyond that associated with core ADHD symptoms, in a range of domains (Barkley & Fischer, 2010).

Masking was mentioned by participants as an area of importance when talking about female ADHD. Even as early as primary school age, participants reported that girls with ADHD may mask behaviours to fit in socially to avoid social impact associated with ADHD and related emotional impulsivity. Masking ADHD behaviours to fit in often results in differences in behaviours across settings (i.e., home and school). Variations in behaviour across settings are consistent with findings from our previous qualitative study, suggesting that symptoms in females with ADHD are more pronounced in environments where individuals feel safe/comfortable (Williams, Barclay et al., 2025). Masking of ADHD symptoms may be a reason why females

are not identified by others as having ADHD (Morgan, 2024).

Participants also reported that females with ADHD may receive scaffolding or support from others, which may reduce or buffer difficulties when younger. However, masking and support are not always effective in mitigating ADHD difficulties, and difficulties may present when demands increase in secondary school. Further, females may not be identified as having ADHD until they are older, when support in school is reduced, and they become overwhelmed and are unable to mask due to the increase in demands (Williams, Barclay et al., 2025).

The presentation of ADHD symptoms may differ between females and males for a variety of reasons, including socio-cultural factors (Martin, 2024). Due to gendered social expectations, females are socialised to be organised, empathetic and agreeable to others (Attoe & Climie, 2023), which may encourage them to mask or compensate for their ADHD symptoms. Consequently, females may present with more inattentive, internalised or less externally disruptive hyperactive symptoms, as found in our results, which, due to gendered expectations, may not be interpreted as ADHD by others (i.e., parents/carers and professionals). Therefore, behaviours that may prompt referral for an ADHD diagnosis in males may be less prominent in females (Sciutto et al., 2004), with differences in symptom presentation and expectations delaying recognition and diagnosis of ADHD in females. As such, the current diagnostic criteria may not be well suited to diagnosing female ADHD as they do not fully capture their symptoms or include relevant gender-inclusive symptom descriptions.

This study is novel as it explores the manifestation of childhood ADHD symptoms in females, including symptoms beyond established diagnostic criteria, from the perspective of parents/carers of females with ADHD and professionals with substantial experience of working with girls with ADHD. Additionally, as some participants mentioned being both a professional and a parent/carer to a child with ADHD or even having ADHD themselves, they may have had insight into female ADHD symptoms and behaviours that others may not have. However, this is also a limitation as the sample was self-selected and may not be representative of parents and the professionals who support children with ADHD. Further, only one parent/carer had a nonbinary child. Future work should aim for more gender diversity. The findings may not be exclusive to females with ADHD, as ADHD might manifest in a similar way in some males also. Additionally, information about the medication status of parents/carers of children with ADHD was not recorded. This means the study is unable to report on whether medication affects masking abilities in females with ADHD across the day. However, most children diagnosed with ADHD in the UK will be offered medication, including a long-acting formulation. Future studies and clinical practice should consider whether long-acting

ADHD medications reduce differences between behaviour at home and school.

The findings of this qualitative study highlight that girls with ADHD may experience difficulties not fully described in existing diagnostic criteria. These behaviours include additional inattentive behaviours (e.g., losing track of one's own thoughts), verbal and subtle hyperactivity/impulsivity, difficulties with emotional regulation and impulsivity and greater difficulties in safe environments due to masking in places like school. The results suggest that when assessing ADHD, professionals should consider environments outside of home and school, especially places where young people feel safe. Additionally, the findings highlight that difficulties regulating emotion and emotional impulsivity may be important in females with ADHD. Emotional regulation difficulties are a transdiagnostic difficulty. Further research is needed to better understand which aspects may be especially relevant to ADHD in females. Future research should also consider whether current ADHD diagnostic assessments and criteria require improvement for female ADHD, including adding to or adapting existing symptom examples in the diagnostic criteria. This may aid earlier recognition and diagnosis of ADHD in primary school-age children, especially females, as it could increase awareness of more gender-inclusive ADHD symptoms, including those that may be less overt or more inattentive, which may not align with traditional conceptualisations of ADHD.

Acknowledgements

This work was supported by the Wolfson Centre for Young People's Mental Health, established with support from the Wolfson Foundation. We would like to thank Daniel Oakes from NCMH for help with REDCap, Megan Holland from ADHD Foundation for help with recruitment, our Youth Advisory Group of young people with lived experience of neurodevelopmental conditions and our study participants.

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Ethical Approval and Informed Consent

This study was approved by the Cardiff University School of Medicine Research Ethics Committee (SMREC 23/28). All participants provided written consent to take part in this research, and consented to its subsequent publication, prior to participation.

Author Contributions

T.W. (first author): study design, data collection and analysis, manuscript writing and revision. R.B.-J., L.A.L.: study design, manuscript editing. I.B.: data analysis, manuscript editing.

S.S.A., T.F., A.J., K.P., A.T.: manuscript editing. J.M. (senior author): acquisition of funding, study design, manuscript writing and editing, supervision.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by Health and Care Research Wales (HCRW) via an NIHR Advanced Fellowship (Ref: NIHR-FS(A)-2022). RBJ was supported by a HCRW Advancing Researcher Award (AR-23-17).

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Data Availability

The data that supports the study findings are available as quotes in the paper. Interview schedules are available as Supplemental Materials. Information sheets are available from the authors upon request. Full data transcripts are not available, as this would violate ethical approval and the agreement to which the participants consented.

Supplemental Material

Supplemental material for this article is available online.

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