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The Clinical Profile of ADHD in Adult Women: Psychiatric Comorbidities

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ABSTRACT

ADHD is historically underdiagnosed in females. This systematic review examines the main psychopathological comorbidities and affective correlates characterizing adult women. Following PRISMA guidelines, a search was conducted across Google Scholar, PubMed, and PsycINFO (2015–2025) for studies analyzing psychiatric comorbidities in adult women with ADHD. Out of 218 records, eight studies met the inclusion criteria. The review synthesized data from 3,563,887 women (45,856 diagnosed with ADHD). Women with ADHD present a more complex clinical profile than both men with ADHD and neurotypical peers. Major depression and anxiety disorders are the most frequent comorbidities, alongside high prevalences of eating disorders, borderline personality disorder, and suicidal ideation. Emerging evidence underscores a critical interaction between ADHD and female reproductive life-cycle stages, showing significantly worsened emotional distress during premenstrual phases, the postpartum period, and perimenopause. Methodologically, emotional dysregulation and alexithymia remain under-measured and are largely inferred indirectly. ADHD in women is a multidimensional condition characterized by persistent internalizing vulnerabilities that cause severe diagnostic delays. Clinical practice must adopt gender-sensitive diagnostic tools and integrated interventions targeting emotional regulation and hormonal life-stage transitions.

Keywords: Adult Women; ADHD; psychiatric comorbidities; emotional dysregulation.

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Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterized by two main domains—inattention and hyperactivity/impulsivity—which may manifest independently or in combination. The disorder typically emerges during childhood, tends to persist throughout development, and occurs across multiple life settings, significantly impacting daily functioning (American Psychiatric Association, 2013). For many years, ADHD has been underdiagnosed among females; only recently has research begun to explore more systematically the manifestation of symptoms in women and their impact on psychosocial functioning (Fratlicelli et al., 2022). Hinshaw et al. (2022) identify several reasons underlying this underdiagnosis: in girls, inattentive symptoms predominate, while disruptive behaviors typical of hyperactive/impulsive profiles are less frequent. Furthermore, many women adopt compensatory strategies that mask the symptoms. Finally, a long-standing belief has persisted among professionals that ADHD is rare in females and more characteristic of males. Available evidence shows that women with ADHD have a higher prevalence of internalizing disorders than both women without ADHD and men with the same diagnosis (Fuller-Thomson et al., 2016). Internalizing disorders are psychopathological conditions in which emotional distress tends to manifest primarily “inwardly,” rather than through externalized behaviors. Such manifestations include anxiety, depressed mood, emotional withdrawal, somatization, and increased vulnerability to stress (Young et al., 2020; Helgesson et al., 2023). This clinical profile, often less evident at the behavioral level, may lead to a higher risk of delayed or misdiagnosis, as internalizing symptoms can overlap with or mask the core features of ADHD (Bennett & Gibb, 2022). In women, these characteristics outline a symptomatic pattern that differs from the more externalizing profiles common in males, frequently including anxiety, depression, and somatic symptoms. The predominance of inattentive symptoms alongside internalizing manifestations contributes to greater subjective distress and negative repercussions on self-esteem, interpersonal relationships, and quality of life, especially in the presence of delayed diagnoses (Kelly et al., 2024). ADHD in women is also frequently associated with other mental health conditions, including depression, anxiety, self-harm, eating disorders, and substance use (Callahan et al., 2025). These issues are often compounded by relationship difficulties and significant impacts on daily and professional functioning (Kelly et al., 2023). The presence of multiple comorbidities may also increase the risk that symptoms being misinterpreted as indicative of personality disorders or other internalizing disorders, making the recognition of ADHD and access to appropriate treatment even more complex (Fratlicelli

et al., 2022). In light of these factors, this systematic review aims to critically examine the existing scientific literature on the main clinical symptoms comorbid with ADHD in adult women, focusing, specifically on internalizing disorders.

Method

Literature Search

The search was conducted with the aim of identifying studies that analyzed psychiatric comorbidities in adult women diagnosed with ADHD. The review was conducted in accordance with the guidelines of the PRISMA Statement guidelines (Page et al., 2021) to ensure rigor and transparency in the process of identifying and selecting articles. The literature search was performed across three scientific databases: Google Scholar, PubMed, and PsycINFO. The following search string was used:

“Adult women” AND (“ADHD” OR “Attention Deficit Hyperactivity Disorder”) AND (“psychiatric comorbidities” OR “emotional dysregulation” OR “anxiety” OR “depression” OR “alexithymia”).

Inclusion and Exclusion Criteria

Studies meeting the following criteria were considered eligible for inclusion in the review:

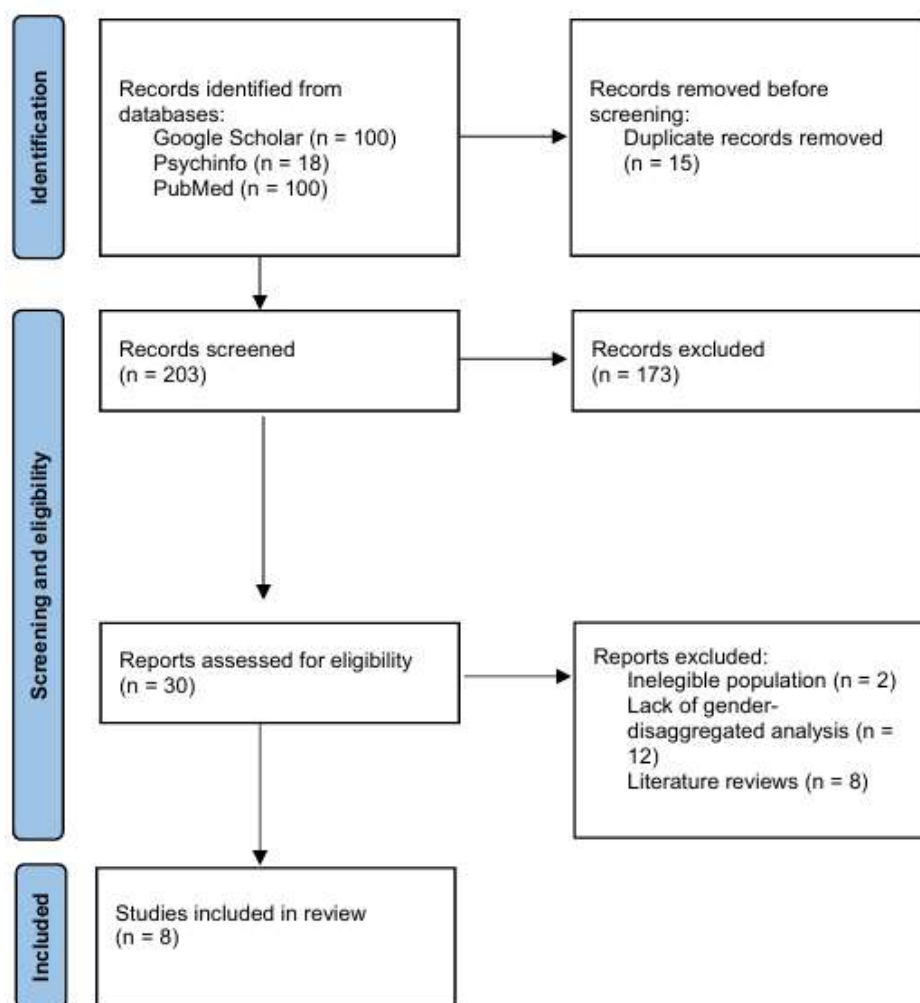
- Published within the last ten years (2015–2025). A 10-year timeframe was selected because this period has witnessed a significant increase in studies specifically focused on women with ADHD. Restricting the search to the last decade ensures the analysis of the most recent and updated literature available.
- Samples consisting of adult women diagnosed with ADHD;
- Analysis of relevant clinical symptoms, including anxiety, depression, emotional dysregulation, and alexithymia;
- Articles published in English.
- Studies meeting any of the following criteria were excluded:
 - Participants under the age of 18.
 - Studies focused exclusively on gender differences in ADHD presentation, without examining psychiatric comorbidities.

Selection Procedure

The selection of articles followed the steps outlined in the PRISMA flow diagram (Figure 1). During the identification phase, a total of 218 records were identified: Google Scholar ($n = 100$), PsycINFO ($n = 18$), and PubMed ($n = 100$). After removing duplicates, 203 records

remained. During the screening phase, all 203 records were evaluated based on title and abstract. Of these, 173 articles were excluded because they did not meet the pre-established inclusion criteria, leaving 30 articles for full-text evaluation. In the eligibility phase, the 30 full-text articles were analyzed in depth. Twenty-two studies were excluded for the following reasons: lack of gender-disaggregated analysis ($n = 12$), participant age not meeting the criteria ($n = 2$), and articles classified as narrative reviews or irrelevant ($n = 8$). Finally, 8 studies were deemed eligible, including in the final sample of the review.

Figure 1. Flow diagram illustrating the study selection process



Results

Table 1 outlines the classification of the included studies, specifying authors, year of publication, country, sample characteristics, and research design. This review examined eight studies analyzing psychiatric comorbidities in adult women diagnosed with ADHD. The variables investigated across these studies include: comorbid disorders (present in all studies), ADHD symptoms ($n = 3$),

internalizing problems ($n = 4$), substance use ($n = 4$), eating disorders ($n = 2$), depressive symptoms and major depression ($n = 5$), anxiety or anxiety disorders ($n = 6$), bipolar disorder ($n = 3$), personality disorders ($n = 4$), suicidal ideation ($n = 2$), somatic symptoms ($n = 3$), sociodemographic factors ($n = 5$), and childhood trauma ($n = 1$). The studies originate from various countries, reflecting a growing international interest in the clinical profile of ADHD in females: Norway ($n = 2$), Sweden ($n = 1$), the Netherlands ($n = 1$), Canada ($n = 2$), Spain ($n = 1$), Iceland ($n = 1$).

Experimental Designs

The included studies employ diverse methodological designs, including cross-sectional studies (the most frequent), multicenter observational studies, population-based national registry studies, observational cohort studies (e.g., SAGA), telephone surveys, and naturalistic analyses in clinical settings. This methodological heterogeneity provides a multidimensional perspective on ADHD in adult women, integrating clinical, psychological, sociodemographic, and reproductive life cycle viewpoints.

Participants

A total of 3,563,887 adult women were analyzed, including 45,856 with a diagnosis of ADHD and 3,518,031 without. The selected studies show considerable variability in sample size, healthcare setting, diagnostic criteria, and age groups. Three studies (Chen et al., 2018; Solberg et al., 2018; Jakobsdóttir Smári et al., 2025) utilize national registries or large cohorts comprising hundreds of thousands of participants. Conversely, studies by Anker et al. (2018), Dorani et al. (2021), and Piñeiro-Díez et al. (2016) focus on participants already under the care of specialist services. These samples reflect populations with complex clinical presentations and a higher likelihood of comorbidities, typical of outpatient settings. Fuller-Thomson et al. (2016) and Vingilis et al. (2015) utilized self-report questionnaires targeting the general population; although these samples were relatively large, they are limited by the subjective nature of self-report diagnoses. While some studies include only women (Dorani et al., 2021; Fuller-Thomson et al., 2016; and Jakobsdóttir Smári et al., 2025), others are based on mixed-sex samples (Anker et al., 2018; Chen et al., 2018; Piñeiro-Díez et al., 2016; Solberg et al., 2018; Vingilis et al., 2015). ADHD identification methods vary from clinical diagnoses recorded in health systems (Sweden, Norway, parts of Spain) to self-reported diagnoses common in surveys (Canada, Iceland) and outpatient clinical assessments (Norway, the Netherlands, Spain). Age groups also differ: some studies cover the entire adult population (18–64 years, as in Chen et al., 2018), while others target specific stages (35–55 years in SAGA; 20–39 years in Fuller-Thomson et al., 2016), or comparison between reproductive age and peri/postmenopausal subgroups (Dorani et al., 2021).

Table 1. Summary of included observational studies, featuring sample characteristics, variables measured, assessment tools, and key findings related to ADHD in women.

Authors and year	Type of study	Participants	Measured variables	Tools	Results
Anker et al. (2018)	Cross-sectional study, naturalistic design, adult patients diagnosed with ADHD	548 adults in an outpatient clinic in Oslo, Norway. 277 women.	- comorbid psychiatric disorders -typo in ADHD -QI	-DSM IV for ADHD diagnosis -Mini-International Neuropsychiatric Interview (M.I.N.I.) -Wechsler Adult Intelligence Scale-III (WAIS-III)	-53.3% of the sample had at least one comorbid psychiatric disorder Women: -36 women (13%) had eating disorders (bulimia and anorexia) -major depression, a comorbid disorder more prevalent in women -PTSD -Agoraphobia
Chen et al., (2018)	Cross-sectional study	5,551,807 adults, 18-64 years old. 61,129 diagnosed with ADHD. 26.737 ADHD women 2.704.211 non-ADHD women	-ADHD diagnosis -Comorbid conditions: psychiatric (substance use disorder, depression, bipolar disorder, and anxiety) and metabolic (type 2 diabetes mellitus and hypertension) -gender and age	-Swedish National Patient Registry -clinical diagnosis based on ICD-9 and ICD-10	-All comorbid conditions examined were more prevalent in ADHD adults -3 most common comorbidities in women: anxiety (44.65% in the ADHD sample), depression and addictions. -depression, bipolar disorder, and anxiety more prevalent in ADHD women than in men

Dorani et al. (2021)	Cross-sectional study	209 women, all meeting DSM-IV criteria for ADHD, from a clinic in the Netherlands. 174 were of reproductive age and 35 were perimenopausal or postmenopausal.	-Premenstrual Dysphoric Disorder (PMDD) symptoms -Symptoms of Postpartum Depression (PPD) -climacteric (menopausal) symptoms - comorbid psychiatric disorders -use of drugs -chronobiological characteristics of sleep	-Diagnostic Interview for ADHD in adults 2.0 (DIVA 2.0) -Mini-International Neuropsychiatric Interview Plus (M.I.N.I. Plus) versione 5.0.0 -M.I.N.I. Plus, 13 questions about PMDD -Edinburgh Postnatal Depression Scale (EPDS) -Greene Climacteric Scale (GCS) -Munich Chronotype Questionnaire (MCTQ)	-PMDD prevalence present in 45.5% of participants (28.7% in the comparable general population) -PDD symptoms present in 57.6% of women after first birth (14.5% prevalence in high-income countries) -significantly more severe climacteric symptoms compared to Dutch normative scores -contraceptive use, fewer PMDD symptoms; antidepressant use, more PMDD symptoms -no significant differences in sleep between groups with and without PMDD, PPD, or climacteric symptoms
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Fuller-Thomson et al., (2016)	Cross-sectional study, Canadian Community Health Survey-Mental Health	Women aged 20-39, 107 with self-reported diagnosis of ADHD and 3801 without ADHD	-psychiatric conditions (major depressive disorder, generalized anxiety disorder, suicidal ideation) -physical health (insomnia, chronic pain) -substance abuse, smoking, physical activity -childhood adversity (sexual and physical abuse before age 16) -sociodemographic variables	- WHO-Composite International Diagnostic Interview (CIDI) for psychiatric symptoms -self-report questions	-ADHD women have a three-fold higher prevalence of suicidal ideation and generalized anxiety disorder, and a twice-higher prevalence of major depression and substance abuse - Higher prevalence of insomnia and chronic pain - Higher prevalence of childhood sexual and physical abuse
Jakobsdóttir Smári et al., (2025)	Population-based cohort study. Icelandic Stress and Gene Analysis (SAGA).	5392 women, ages 35-55. 535 with self-reported diagnosis of ADHD, 4857 without diagnosis	-ADHD diagnosis and symptoms - perimenopausal symptoms -psychological symptoms (depressive mood, irritability, anxiety, tiredness) -somatic symptoms (hot flashes, sleep problems, joint problems) -Urogenital symptoms	-Menopause Rating Scale (MRS) -Adult ADHD Self-Report Scale (ASRS-v1.1) -Patient Health Questionnaire (PHQ-15)	-ADHD women with significantly higher perimenopausal symptoms -psychological symptoms with significantly greater burden related to the perimenopausal period -ADHD appears to significantly increase the likelihood and severity of symptoms such as depression and anxiety in perimenopause

Piñeiro-Diequez et al., (2016)	Cross-sectional, multicenter, observational study. Spain	367 adult patients >18 years. 100 women	-psychiatric comorbidities (anxiety, mood disorders, substance use disorders, eating disorders, personality disorders, conduct disorders) -socio-demographic factors -medical history	-DSM-IV-TR for diagnosis -Data collection from electronic records	-more common disorders in women: eating disorders, major depressive disorder, borderline personality disorder, slightly higher prevalence of anxiety disorders and obsessive-compulsive disorder
Solberg et al., (2018)	Cross-sectional, population-based study, Norwegian national registers	1,701,206 adults (829,876 women), 40,130 ADHD (17,815 women)	-ADHD diagnosis -psychiatric comorbidities (anxiety, depression, bipolar disorder, personality disorders, schizophrenia, substance use disorder) -socio-demographic variables	-Swedish national registers (Medical Birth Registry of Norway—MBRN; Norwegian Prescription Database—NorPD; Norwegian Patient Registry—NPR; National Educational Database—NUDB) -ICD-10	-ADHD women as a vulnerable group -53.3% of ADHD women had at least 1 of 6 psychiatric disorders (13.7% of non-ADHD women) -ADHD women have higher prevalence of all disorders except schizophrenia and substance use - significant prevalence difference in women for depression 24.4% (vs 13.1% men), anxiety 22.1% (vs 11.4% men), bipolar disorder 11.9% (vs 7.9%), personality disorder 12.3% (vs 7.6%)

Vingilis et al., (2015)	Cross-sectional study, telephone survey. Ontario, Canada.	4014 adults, 76 ADHD women and 2023 non-ADHD women	-ADHD symptoms -psychiatric comorbidities -use of drugs -antisocial behavior -substance use -road accidents and arrest for criminal offenses -socio-demographic variables	- Adult ADHD Self-Report Scale-V1.1 (ASRS-V1.1) -General Health Questionnaire (GHQ12) - Mini-International Neuropsychiatric Interview (MINI-APD) -Alcohol Use Disorders Identification Test (AUDIT) -Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	-ADHD symptoms particularly associated with internalizing outcomes (anxiety, depression, use of anxiolytic and antidepressant drugs, use of pain medications) -driving problems, road accidents
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Assessment Tools

The tools used to diagnose ADHD vary considerably, reflecting differences in healthcare settings and data collection periods. Some studies use DSM-IV or DSM-IV-TR criteria, while others rely on ICD-9 or ICD-10 classifications. Specific diagnostic instruments include DIVA 2.0 (Dorani et al., 2021), ASRS-V1.1 (Jakobsdóttir Smári et al., 2025; Vingilis et al., 2015). The coexistence of formal clinical criteria and self-administered scales highlights different diagnostic approaches, which may impact the comparability of results. Psychiatric comorbidities were assessed using various instruments, selected based on the study design: M.I.N.I. International Neuropsychiatric Interview (three studies) and CIDI. For epidemiological screening of psychiatric disorders, tools such as the PHQ-15 (somatic symptoms), GHQ-12 (psychological well-being), AUDIT, and ASSIST (alcohol and substance use) were used. Studies analyzing hormonal cycle-related symptoms utilized targeted instruments, including the M.I.N.I. Plus, the Edinburgh Postnatal Depression Scale (EPDS), Greene Climacteric Scale (GCS), and Menopause Rating Scale (MRS).

Comorbidity and Risk Profile in Women with ADHD

Analysis of the five studies with mixed-sex samples consistently shows that women with ADHD present a more complex clinical profile than both men with ADHD and women without the diagnosis. In the clinical sample by Anker et al. (2018), approximately half of the participants had at least one psychiatric comorbidity, with high prevalences of major depressive disorder and eating disorders—conditions that amplify the functional impairment of ADHD. Similar trends emerge from the Swedish national registry data (Chen et al., 2018), where depression, anxiety, and bipolar

disorder were significantly more common in women than in men with ADHD. The multicenter study by Piñeiro-Díez et al. (2016) confirms this pattern, showing a significantly higher prevalence of eating disorders, major depression, and borderline personality disorder among women with ADHD—conditions associated with marked relationship difficulties and an increased risk of suicide. Findings from Norwegian registries analyzed by Solberg et al. (2018) further reinforce this evidence: over half of women with ADHD have at least one of the comorbid conditions considered, and the prevalence of depression, anxiety, bipolar disorder, and personality disorders is consistently higher than in men. The authors emphasize the importance of early recognition of ADHD in women to prevent progression to more severe clinical presentations. Finally, the study by Vingilis et al. (2015), conducted in the general Canadian population, shows that in women, ADHD symptoms are strongly associated with internalizing problems such as anxiety, depression, and the use of psychotropic medications. The findings highlight a critical issue: many women are identified by healthcare services only when secondary symptoms appear, while ADHD remains undiagnosed, with repercussions on treatment and clinical outcomes. In the three female-only studies samples, this vulnerability is even more pronounced. Fuller-Thomson et al. (2016) documented that major depression, generalized anxiety disorder (GAD), suicidal ideation, insomnia, and chronic pain are significantly more prevalent in women with ADHD than their peers. The authors also note greater exposure to childhood traumatic events, such as sexual abuse, which constitutes an additional vulnerability factor in adulthood. Finally, the most recent studies (Jakobsdóttir Smári et al., 2025; Dorani et al., 2021) introduce the dimension of hormonal fluctuations. The Icelandic study indicates that women with ADHD experience a marked worsening of psychological symptoms—particularly anxiety, depression, irritability, and fatigue—during perimenopause, suggesting that this phase represents a period of particular psychological fragility. Dorani et al. (2021) report a high prevalence of Premenstrual Dysphoric Disorder (PMDD), postpartum depression, and severe menopausal symptoms, suggesting a complex interaction between ADHD, mood regulation, and hormonal physiology.

Discussion

The aim of this review was to analyze the main psychopathological comorbidities associated with ADHD in adult women, with a particular focus on internalizing disorders and affective correlates. Overall, the findings present a picture consistent with the international literature (Attoe & Climie, 2023; Fraticelli et al., 2022; Hinshaw et al., 2022; Kelly et al., 2023; Young et al., 2020) and with the recent review by French et al. (2023), confirming that women with ADHD represent a group characterized by marked psychopathological vulnerability and a multidimensional impact of the

disorder on emotional, cognitive, and relational functioning. In particular, internalizing disorders—specifically major depression and anxiety disorders—emerge as the most common and clinically relevant comorbidities. Women with ADHD exhibit significantly higher levels of emotional distress compared to both women without a diagnosis and men with ADHD, supporting the hypothesis of a female phenotype that tends to manifest primarily through internalizing symptoms. This profile, which is less evident at the behavioral level, helps explain the frequent diagnostic difficulties and delays in the clinical identification of ADHD among women, as previously highlighted by French et al. (2023), while the present review further expands this understanding through its exclusive focus on adult females. Beyond internalizing disorders such as anxiety and depression, the included studies indicate a higher prevalence of eating disorders and personality disorders, particularly borderline personality disorder. Several mechanisms may contribute to these associations. First, chronic difficulties related to executive functioning, emotional regulation, and attentional control often persist undetected for years in women with ADHD due to the predominance of less disruptive symptoms and the tendency to compensate through masking and overcontrol strategies. The prolonged effort required to manage daily demands while concealing difficulties may increase psychological distress, contributing to the development of anxiety and depressive symptoms. Second, emotional dysregulation, increasingly recognized as a central feature of ADHD, may represent a transdiagnostic vulnerability factor linking ADHD to both eating disorders and borderline personality features. Difficulties in identifying, modulating, and tolerating intense emotional states may lead individuals to adopt maladaptive coping strategies, including disordered eating behaviors or impulsive interpersonal responses, as attempts to regulate emotional distress. Furthermore, repeated experiences of academic, occupational, or relational failure, combined with delayed diagnosis and limited access to appropriate support, may negatively affect self-concept and identity development. Over time, these experiences can foster feelings of inadequacy, rejection sensitivity, unstable self-image, and interpersonal difficulties, dimensions frequently observed in borderline personality disorder. Importantly, some characteristics commonly attributed to borderline personality disorder, such as emotional instability, impulsivity, and relational difficulties, may partially overlap with ADHD manifestations, potentially contributing to diagnostic complexity and comorbidity. Finally, gender-related sociocultural factors may further amplify these risks. Women are often exposed to stronger expectations regarding self-regulation, organization, emotional management, and caregiving roles. When ADHD-related difficulties interfere with these expectations, the resulting discrepancy may increase self-criticism, shame, and psychological burden, thereby exacerbating vulnerability to comorbid psychopathology. Taken together, these findings suggest that the

elevated rates of psychiatric comorbidity observed among adult women with ADHD are likely the result of an interaction between neurodevelopmental vulnerabilities, emotional dysregulation processes, cumulative psychosocial stressors, delayed recognition of symptoms, and gender-specific contextual pressures. A key finding that emerged from this review concerns the assessment of emotional dysregulation. Although recognized as a central dimension of ADHD functioning, it is not measured directly in the included studies but is instead inferred through indicators of anxiety, depression, or psychological distress. This methodological shortcoming, which is less explicitly addressed in the review by French et al. (2023), limits the ability to consider emotional dysregulation as an autonomous transdiagnostic process and suggests that its clinical relevance in the female ADHD phenotype may be underestimated. A similar critical issue concerns alexithymia, which is also not assessed using specific instruments, despite its potential mediating role between emotional vulnerability, relational difficulties, and daily functioning. Another aspect that has emerged—and which has been only marginally addressed in the general literature—concerns the possible role of hormonal fluctuations in modulating emotional vulnerability in women with ADHD. Some studies report an association between ADHD and specific life-cycle stages, such as premenstrual dysphoric disorder (PMDD), postpartum depression, and perimenopause. Although this evidence is still preliminary, it suggests that the interaction between ADHD and hormonal factors may help explain the variable course of emotional functioning in adult women, broadening the perspective proposed by French et al. (2023) toward a more dynamic and life-stage-sensitive interpretation. In support of this interpretation, recent studies indicate that in women, the associations between ADHD symptoms, self-reported cognitive difficulties, and emotional dysregulation tend to remain stable throughout the adulthood, unlike what is observed in men, in whom these associations diminish with age. This pattern reinforces the hypothesis of persistent emotional vulnerabilities in the female ADHD profile and underscores the need for gender-sensitive clinical and intervention models. Finally, the review highlighted marked methodological heterogeneity among the included studies, which encompass health registries, clinical trials, and self-report surveys. While this variability complicates the direct comparison of results, it also reinforces the strength of the evidence when converging patterns emerge, such as the prevalence of internalizing disorders and the greater psychopathological complexity of the female profile. Overall, building on and expanding the findings of French et al. (2023), the results suggest that the female phenotype of ADHD is characterized by a combination of emotional, relational, and contextual vulnerabilities that calls for more sensitive assessment tools and targeted clinical interventions capable of capturing the specific nature of neurodivergent functioning in adult women.

Limitations

This review has certain limitations that should be taken into account when interpreting the results. First, the decision to include only studies published in English and within the last decade (2015–2025) may have introduced a potential selection bias. While this approach ensures the review is up-to-date and accessible, it may have excluded relevant earlier studies or those published in other languages. Second, the search was conducted across a limited number of databases. Although including Google Scholar increases sensitivity, it may reduce specificity, making the process more difficult to trace and fully replicate. Another limitation concerns the methodological heterogeneity of the included studies. These works differ in design (clinical trials, national registries, and surveys) and diagnostic criteria (DSM vs. ICD). Furthermore, methods of identifying ADHD varied from clinical diagnoses to self-reports, and the age groups considered were inconsistent. This variability limits direct comparability and prevents the derivation of robust summary estimates via meta-analysis. Furthermore, the quality of the evidence is affected by the study designs. Many included studies are cross-sectional, which reduces the ability to infer causal relationship or clarify the direction of the link between ADHD and its comorbidities. Finally, a specific limitation involves the assessment of emotional dysregulation and alexithymia. Although these were included in the search criteria, the selected studies rarely employ specific measures for these constructs. Instead, they are often inferred indirectly through indicators of anxiety, depression, or distress. This reduces construct validity and limits the ability to isolate transdiagnostic processes that may be central to the female phenotype of ADHD. Overall, these limitations suggest caution in generalizing the results. They point to the need for future studies that are more standardized, longitudinal, and sensitive to gender and life-cycle specificities.

Conclusions

This review highlights that ADHD in adult women is a complex and multidimensional clinical condition. It is characterized by a high prevalence of psychopathological comorbidities, particularly internalizing disorders, emotional vulnerability, and affective-relational difficulties. Taken together, the analyzed studies confirm that the female profile of ADHD tends to manifest less through disruptive behaviors and more through emotional distress, affective dysregulation, and internalizing symptoms. These factors contribute to diagnostic delays and clinical underestimation of the disorder. The higher frequency of depression, anxiety, eating disorders, and personality disorders suggests that ADHD in women should not be treated as a simple quantitative variant of the male phenotype. Instead, it requires a specific interpretation that is sensitive to gender

and developmental trajectories. A significant contribution of this review concerns the emergence of emotional dysregulation as a possible central transdiagnostic node, despite the absence of its direct assessment in most of the included studies. Similarly, alexithymia—which is potentially implicated in difficulties with emotional awareness and relational distress—is systematically overlooked in methodological terms. These gaps limit our ability to clarify the mechanisms through which ADHD in females is associated with complex psychopathological outcomes and suggest the need for a shift in research paradigms. Future studies should systematically incorporate specific instruments for assessing emotional regulation and alexithymia, adopt longitudinal designs, and explicitly consider the role of gender, age, and life-cycle transitions. In this context, emerging evidence on the potential impact of hormonal fluctuations—from the premenstrual phase to perimenopause—opens up a further promising line of research. Although preliminary, these findings indicate that the interaction between ADHD, hormonal balance, and emotional vulnerability may amplify psychological distress during specific life stages. This requires more integrated theoretical and clinical models. The hypothesis that emotional vulnerabilities persist in women across different stages of adulthood reinforces the need to move beyond a view of ADHD limited to childhood or young adulthood. This is supported by recent studies on the interactions between ADHD symptoms, subjective cognitive difficulties, and emotional regulation. From a clinical and intervention perspective, these findings suggest the importance of diagnostic and therapeutic approaches that go beyond the assessment of core ADHD symptoms. Such approaches must systematically include emotional functioning, internalizing comorbidities, and the individual's affective and relational history. Psychological interventions targeting emotional regulation, awareness and recognition, as well as the treatment of comorbidities, appear particularly relevant for adult women with ADHD. Finally, greater awareness among clinicians regarding gender-specific factors could help reduce diagnostic delays and promote more timely and personalized treatment pathways.

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