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"That's not what ADHD is": Australian Schooling Experiences of Female Students with ADHD: An Interpretative Phenomenological Analysis

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Abstract

The current study aimed to explore the lived experience of female students (aged 10-19 years) with Attention-Deficit/Hyperactivity Disorder (ADHD) in school. Females with ADHD are largely under-represented in ADHD research. Growing research suggests that differences in symptom presentation, comorbidities, stereotypes and stigma, and diagnostic bias have each contributed to under-detection and under-support of females with ADHD, especially in the school setting. Under a critical realist framework and qualitative paradigm, seven semi-structured interviews were conducted and analysed with an Interpretative Phenomenological Analysis (IPA) methodology. The IPA revealed three key group experiential themes about the school experience of females with ADHD: (i) being understood and self-understanding; (ii) navigating autonomy and support; and (iii) neurodiversity in social experiences. Within these three group experiential themes, eight subthemes were identified:teacher understanding of ADHD; bias, stereotypes, and stigma; self-understanding and self-advocacy; independence and increasing expectations; independence and increasing expectations; balancing overbearing and effective support; peer understanding of ADHD challenges; and neurodivergence and barriers to connection. These group experiential themes and subthemes shaped the school experiences of the participants, contributing to their self-efficacy and the accessibility of learning support, their interactions with peers and teachers, and how they conceptualised their own ADHD-related challenges. These findings contribute to a growing understanding of how ADHD is experienced by females. Additionally, the current study highlights the need for greater teacher and peer education to improve the quality and accessibility of school-based support as well as the need to address issues of ignorance, stigma and stereotyping that shape the experience of females with ADHD.

Keywords: Lived Experience, ADHD, School, Children, Female, Neurodiversity, Neurodevelopmental

1. "That's not what ADHD is": Australian Schooling Experiences of Female Students with ADHD: An Interpretative Phenomenological Analysis

Attention-Deficit/Hyperactivity Disorder (ADHD) is a highly prevalent neurodevelopmental disorder typified by challenges with attention, hyperactivity and/or impulsivity [1]. Current prevalence estimates suggest that approximately 6-10% of young people in Australia are diagnosed with ADHD [2]. ADHD is widely considered to have a strong genetic component, with twin studies estimating 74% to 92% heritability, and is more common in males, with the Diagnostic and Statistical Manual 5th edition Text Revision (DSM-5-TR) reporting a male to female ratio of 2-2.5:1 [1,3]. ADHD has three diagnostic subtypes; predominantly inattentive, predominantly hyperactive/impulsive, and combined presentation [1]. As described in the DSM-5-TR, the predominantly inattentive subtype presents as difficulties with sustained attention, difficulties following and attending to instructions, and organisational difficulties [1]. The hyperactive/impulsive subtype may include symptoms like fidgeting, difficulty staying still, excessive talking and interrupting behaviours, whereas the combined subtype involves presentation with both inattentive and hyperactive/impulsive features [1]. ADHD presentation and symptoms can change throughout the course of development, generally stabilising in adolescence, but continuing into adulthood [1]. Recent research suggests that females are substantially more likely than males to be diagnosed with the predominantly inattentive subtype with a standardised mean difference of 0.14-0.23 [4]. Regardless of the subtype, students with ADHD experience significant difficulties

at school, including academic underachievement, difficulty with classroom engagement, and stigmatisation [5,6]. Students with ADHD struggle with academic progress, and have an increased likelihood of detentions, suspensions, and exclusions from school due to disruptive or defiant conduct leading to lifelong impacts indicating a need for improved school-based support [5,7].

ADHD was previously considered a largely male-dominant disorder, however there is growing research into differences and prevalence in ADHD between genders [7,8]. Recent estimates of the diagnostic prevalence of ADHD in children and adolescents suggests that males are up to two-and-a-half times more frequently diagnosed with ADHD than females [1,9,10]. The diagnostic prevalence in females marginally increases in adulthood compared to childhood rates, suggesting under-detection of ADHD in childhood is resulting in late diagnosis for females [11,12]. In a cross-sectional cohort study of 85,330 males and females with ADHD in Sweden, Skoglund et al. identified that females receive an ADHD diagnosis approximately 4 years later than males, and represent greater psychiatric comorbidity and health care utilisation compared to males and non-ADHD female groups [13]. This delay in diagnosis suggests that there may be under-recognition of ADHD in school-aged females [13]. Under-detection of ADHD in female children contributes to reduced access to intervention and support, impaired educational engagement, as well as increased stress and psychiatric comorbidity [5,13]. Additionally, Young et al., in their expert consensus statement, highlight that ADHD diagnosis can be overlooked by teachers and attributed to other conditions, such as a specific learning disorder, mood disorder, or anxiety disorder, due to a lack of knowledge surrounding ADHD identification [7]. Overall, increased awareness of the under-detection of ADHD in females, as well as the different challenges they face compared to males with ADHD, highlights the need for further research into the factors that hinder detection and provision of effective support.

1.1. Distinguishing Sex and Gender

Much of the research conducted on ADHD treats sex and gender as interchangeable terms [14]. 'Sex' refers to a binary of biological male or female status assigned at birth (acknowledging this is not a binary classification). Conversely, 'gender' refers to socio-cultural roles and expectations attributed to biological sex. Gender reflects an individuals' identification with these constructs of masculine and feminine [15]. Without a measure of participant gender identity, the ADHD research referenced throughout this study has largely relied on parent reported sex-assigned at birth [14]. In line with Martin, the current study acknowledges this distinction and uses 'gender', 'female', 'male', 'girl', and 'boy' to refer to the identity self-reported by the participants, as well as how parents and teachers perceive the gender identity of the children [14].

1.2. Current Research on ADHD in Females

Extant literature predominantly attributes under-detection of ADHD in females to a lack of symptom recognition in female children, leading to an absence of referral for ADHD assessment [15]. This lack of ADHD symptom recognition in females is thought to result from a range of factors, such as gendered biases and expectations of how female children behave, differential manifestation of ADHD symptoms, comorbidities, and masking of underlying symptoms [7,16]. According to Hinshaw et al., differences in ADHD symptom presentation between males and females is a key factor that contributes to under-detection in females [15]. Hinshaw et al. suggest that because females with ADHD are more likely to present with internalising symptoms and the inattentive subtype (ADHD-I), whilst males with ADHD more commonly present with externalising symptoms, ADHD may be less noticeable in females [7,15,17].

In a study of 496 teachers, Moldavsky et al., demonstrated that inattentive behaviours were less likely to be rated as being indicative of problems in the classroom setting compared to the hyperactive/impulsive or combined subtypes of ADHD [18]. Because of this, the internalising and inattentive challenges experienced by school students often go unnoticed, generally resulting in a lower likelihood of referral, compared to more disruptive behaviours [5,19]. Similarly, Coles et al. conducted a study of 50 teachers tasked with rating impairment of males and females with varying ADHD subtypes represented in eight vignettes [20]. It was demonstrated that teachers rate inattentive symptom presentations as less severe and less likely to warrant concern compared to hyperactive symptoms [20]. Given that schools are a key source of ADHD referrals, with teachers contributing reports on behavioural symptoms and academic difficulties during professional diagnosis, inattentive presentations may go unnoticed, leading to under-detection in female students [19].

Furthermore, there is a greater frequency of comorbid internalising disorders such as mood and anxiety disorders in females with ADHD compared to females without ADHD and males with ADHD [13]. Females with ADHD are approximately twice as likely to be diagnosed with both anxiety disorders (50.4% vs. 19.5%) and mood disorders (37.5% vs. 19.5%) compared to males with ADHD [13]. Moreover, females with ADHD are 35.1% more likely to be diagnosed with an anxiety disorder and 29.3% more likely to be diagnosed with a mood disorder, compared to females without ADHD [13]. Gender is also a key moderating factor for the presence of comorbidities, with females having greater stability of psychiatric comorbidities across the lifespan [21]. Due to the higher prevalence of mood and anxiety disorders in females with ADHD, these diagnoses can overshadow ADHD recognition, further contributing to under-detection [15]. In their study of 100 females with ADHD, aged 3-18 years, Kopp et al. demonstrated that almost 50% of their samples with ADHD had previously been misdiagnosed by a clinician when consulting for behavioural challenges [22]. The greater prevalence of internalising symptoms may further contribute to diagnostic overshadowing or misdiagnosis, delaying the provision of supports and interventions for ADHD-related challenges [22,23]. This highlights the need for increased research efforts into the diagnostic experiences of females, as well as factors contributing to early referral and detection of ADHD.

There is growing acknowledgement of symptom 'masking' that

may contribute to under-detection of ADHD in females [5,24]. Masking refers to the role of learnt, adaptive, prosocial behaviours that contribute to young people with ADHD outwardly presenting as less impaired, reducing the likelihood of referral and diagnosis [24,25]. The relevance of masking has largely been drawn from the research on the female presentation of Autism Spectrum Disorder [25]. The majority of ADHD masking research has investigated compensatory behaviours in individuals who receive a late diagnosis in adulthood, most commonly adult women [26,27]. Therefore, limited research has been conducted on female children and adolescents regarding how masking may develop to compensate ADHD associated challenges [27]. However, experiences of social adaptation and concealing of symptoms are often reported in qualitative investigations with young people diagnosed with ADHD, highlighting the need for greater investigation into the role of masking [28,29].

ADHD diagnosis is typically based on an assessment by a qualified clinician, and formal diagnostic criteria, behavioural checklist scoring, and qualitative observation, as well as behavioural rating scales completed by the child, parents, and/or teachers [1,16]. In the absence of any biological or physical testing method to confirm an ADHD diagnosis, this diagnostic process is vulnerable to gendered biases in criteria, as well as assumptions around the 'typical' behaviour of females [14,16]. Development of diagnostic criteria has predominantly relied on male samples which may also contribute to the discrepancy in female prevalence rates [29,30]. Lynch and Davison highlight that DSM-5-TR criteria may not accurately reflect the different ways in which females experience and present with ADHD, as well as its lack of guidance on how gender influences symptom presentation due to its focus on symptomatic descriptions based on male samples [16].

Additionally, ADHD symptoms often manifest differently between genders, for example, with male hyperactivity/impulsivity presenting as excessive motor movement and female hyperactivity/impulsivity presenting as excessive talking [31]. Gender differences in symptom presentation are further compounded by gender-stereotyped expectations of normative versus problematic behaviour [16,19]. Hyperactivity or impulsivity screening items are also less likely to be endorsed for female children even when exhibiting comparable trait severity levels to male children [32,33]. In addition, existing diagnostic criteria may lack sensitivity in detecting ADHD symptomology in females, or could result in currently diagnosed females being more severely impaired or more hyperactive, compared to males with similar levels of severity [16,34].

In their investigation of 283 males and females with ADHD aged 7-12 years, compared factors that differentiated between children meeting DSM-5 diagnostic criteria or not [24]. It was identified that girls required a greater burden of emotional and behavioural challenges in order to meet ADHD diagnostic criteria compared to boys [24]. However, Mowlem et al. only had 21% female representation in their sample, which may have caused some gender differences to be statistically under-powered [24]. Biases in diagnostic criteria and ADHD symptom checklists indicate a need to better understand the unique ways in which ADHD manifests in females in order to inform future diagnostic approaches [5]. Compounding this, androcentrism in ADHD research as a whole has resulted in a public perception that ADHD primarily affects males, as the stereotyped understanding of ADHD represents a prototypical male presentation [16,35]. This perception leads to further bias and barriers to female children being referred for and diagnosed with ADHD, often contributed to late diagnosis [7,16].

An additional key factor that limits the referral of female students (compared to males) for ADHD assessment is the role of gender-bias in teacher's symptom appraisal in the classroom. ADHD diagnosis is often instigated and facilitated by teacher referral and rating of behaviour, therefore detection biases in symptom appraisal could contribute to under-detection of ADHD in females [5,36]. Isaksson et al. compared ADHD symptom severity ratings of parents and teachers and found a significant role of gender in symptom appraisal, whereby teacher ratings were significantly lower than parent ratings for female students, with no such difference identified for male students [36]. Additionally, Isaksson et al. found that lower teacher ratings were associated with a significantly greater level of self-reported stress in the students [36]. DSM-5-TR ADHD diagnostic criteria require impairment across home and school contexts. Given this, teachers or parents underrating female students' symptoms presents a major barrier to diagnosis and receiving sufficient academic supports and medication, thus highlighting the need for further research into the barriers to female ADHD detection.

1.3. Key Research on ADHD in Schools

Within the school context, children with ADHD face a range of difficult experiences due to social stigmatisation, stereotyping, invalidation, and alienation. This occurs alongside academic under-achievement and academic disengagement [15]. In their systematic review and thematic synthesis of qualitative analyses on young peoples' lived experience of ADHD, Eccleston et al. identified the prominent role of social pressures that young females with ADHD face in order to align with the social norms and expectations of their peers [37]. Failure to align with social expectations often led to experiences of peer victimisation, social exclusion, and relational conflict [37]. Similarly, Sciberras et al. investigated self- and parent-reported experiences of peer victimisation and social problems in a sample of 22 Australian adolescent females aged 12-18 years and diagnosed with ADHD [38]. Sciberras et al. identified that females with ADHD were more likely to experience overt and relational victimisation through bullying than those without an ADHD diagnosis, however, further research is needed to understand what is driving greater susceptibility to peer victimisation [38]. With this, research also suggests that peers of students with ADHD report more negative attitudes toward ADHD-associated behaviours, which may be a contributing factor [39].

In their qualitative interview study of 10 male and female adolescents with ADHD aged 13-18 years in Norway and Sweden,

Hallberg et al. reported a common desire to 'fit in' with their peers, with the participants often feeling 'different' due to their diagnosis [28]. They also reported shame and embarrassment leading to a desire to hide their diagnosis, as well as feeling antagonised by teachers that viewed them as 'troublemakers', highlighting the role of stigmatisation in shaping school experiences [28]. Moreover, Batzle et al. found that teachers rated children with ADHD less favourably in terms of behaviour, intelligence and personality compared to those without a diagnosis [40]. Ohan et al. identified that a students' ADHD diagnosis heightened teachers' negative expectations and negative emotions toward them, and reduced their confidence in instructing the child [41]. Whilst significant stigma toward individuals with ADHD remains, is it is important to note that with growing awareness and public understanding of ADHD, this widespread stigmatisation may be starting to change [42]. Given the way that stigmatisation shapes the school experiences of students with ADHD, more research is needed to understand how this affects the experience of female students with ADHD.

Furthermore, teachers' understanding, stigmatised beliefs, and self-efficacy surrounding ADHD are key factors in shaping the school experiences of students with ADHD, largely determining the level of support they receive [43]. In their qualitative interview study of 19 primary school teachers in England, Ward et al. identified that teachers reported not feeling knowledgeable about ADHD and expressed a lack of confidence in managing children with ADHD in the classroom [43]. Furthermore, in an investigation of attitudes toward inclusion of children with ADHD in 135 teachers, Toye et al. demonstrated that greater knowledge of ADHD related to less stigmatised beliefs and more positive attitudes toward inclusion of students with ADHD [44]. Teacher knowledge surrounding ADHD is a key factor to the support and identification of female students with ADHD, however little research has been done on the role of teacher knowledge in the experiences of female students with ADHD.

Whilst young people with ADHD face academic challenges, particularly in relation to engagement, literacy, and numeracy, they often face difficulty accessing adequate educational support [36]. In their qualitative interview study of 12 mixed-gender adolescents with ADHD, aged 14-16 years in Canada, Wiener and Daniels identified the role of decreased parental involvement and greater autonomy demands on exacerbating challenges with exercising agency and seeking support for those with ADHD [6]. Adolescents' difficulties with academic engagement were often mislabelled as 'laziness', leading to frustration and reduced teacher support [6]. However, Wiener and Daniels only included three females in their sample, highlighting the need for further research into the experiences of autonomy and help seeking in females with ADHD [6].

1.4. Qualitative Investigations of Female School Experiences

Whilst there is a significant dearth of qualitative research investigating the lived experience of female students with ADHD, there have been some recent efforts to address this gap in the literature. Lynch and Davison investigated the school and social experiences of 17 females with ADHD aged 13-20 years in Ireland, through semi-structured interviews [16]. They conveyed the way that strained relationships with teachers were described and often attributed this to teachers having a poor understanding of ADHD [16]. Inattentive symptoms in the classroom were often not viewed as atypical or problematic, further supporting the role of bias in teacher symptom appraisal [16,36]. Moreover, Lynch and Davison identified barriers that females with ADHD face accessing clinical and educational supports as a result of gendered biases and stereotypes surrounding females with ADHD [16]. This research highlights the need for an updated conceptualisation of ADHD for teachers, clinicians and parents informed by research on the unique experiences of females with ADHD compared to males [16].

Additionally, Mansfield and Soni investigated the experiences of five adolescent female high school students aged 13-14 years diagnosed and with ADHD in England, utilising semi-structured interviews and interpretative phenomenological analysis (IPA) methodology, the authors identified the way executive dysfunction shaped school experiences, described in feelings of frustration and a lack of agency toward challenges with working memory and planning [29]. Mansfield and Soni also highlight that masking behaviours in girls with ADHD often resulted from punitive responses to ADHD-related behaviours, as well as desire to blend in with peers [29]. Additionally, they described the way ADHD was often seen as a positive aspect of identity and self-understanding, but also as a possible cause for exclusion from peers, where girls with ADHD felt they had to be careful with who they disclosed their diagnosis to [29]. Whilst this study contributes to the dearth of qualitative research on girls with ADHD, the use of unstructured interviews may have led to key areas of interest being missed or experiences pertaining to comorbidities being emphasised, highlighting the need for more targeted qualitative research [29].

Despite the above recent efforts to investigate the lived experience of girls with ADHD, this demographic remains underrepresented [35,44]. Across psychopathology publications between 1993-2017, female-only studies only constituted 35.9% of single-sex studies [35]. In their review, Taneja-Johansson highlighted that prior to 2021, only 9% of qualitative studies investigating the experiences of ADHD and ASD in schools had female-only samples, and of mixed-gender studies 74% had majority male samples [45]. To date, no qualitative study of the school experiences of girls with ADHD has been undertaken on an Australian sample [45]. Whilst this is a growing area of research, qualitative investigations of ADHD in females are still largely restricted to adult populations, such as in Stenner et al., and despite recent efforts, female-identifying individuals are still largely underrepresented in ADHD research [7,46]. Furthermore, the limited use of qualitative methodology in ADHD research reflects a broader deficit discourse in disability research, whereby children with disabilities are viewed as having impaired competence and limited insight to share their lived experiences in research [45]. As a result, children's voices are often excluded, with preference given to parent or teacher perspectives

[29,45]. Emphasising qualitative approaches recognises the autonomy of children with psychiatric diagnoses or developmental disabilities, orienting research and intervention toward their lived experiences.

1.5. The Present Study

In light of the above, the current study aimed to investigate and communicate the lived experiences of female-identifying school students with ADHD as well as how they make sense of these experiences. This study will utilise interpretative phenomenological analysis (IPA) to qualitatively investigate the lived experiences of the participants [47]. Specifically, this study will investigate academic experiences, experiences with peers, teacher relationships, barriers to ADHD identification and access to effective support through critical realist framework. No specific expectations or hypotheses are made as the findings of IPA are purely derived from the participants experiences without explicit expectations [47]. This research will utilise a critical realist theoretical framework. Critical realism acknowledges a *real* world of causal relations alongside the subjectivity of experience and therefore knowledge of the world [48]. Critical realism relates to IPA in acknowledging a lack of direct access to reality, due to the inherent limitations of human understanding and perception therefore requiring the interpretation of experiences [48,49].

2. Method

IPA is a qualitative research methodology aimed at providing a rich, idiographic account of the convergent and divergent aspects of the first-person lived experience of a group of individuals, as well as how meaning is drawn from these experiences [47]. IPA was chosen for this study as it maintains contextual sensitivity and ensures a greater level of depth and detail that cannot be captured in a quantitative framework. Additionally, IPA was chosen in place of other qualitative methods due its exploratory nature and participant driven approach being well suited to communicating the experiences of an under-researched group. Given this, IPA is ideal to understand how girls with ADHD conceptualise and attribute meaning to their school experiences.

2.1. Research Design

IPA is based on a strong theoretical foundation that informs its methodology as well as process of analysis and application of the findings. An epistemological and ontological framework is at the core of IPA and describes the nature of the methodology and the findings.

2.1.1. Epistemology and Ontology of IPA

Ontology is a mode of enquiry concerned with the nature of existence, investigating the structure of reality, the nature of being, and what is considered knowable about the world [50]. In the context of qualitative research, ontology refers to the researcher's beliefs about the knowability, constitution, and construction of reality, as well as the existential status of aspects of the social world [51]. Epistemology refers to the assumptions surrounding the nature of knowledge, investigating the foundations, nature, and the possibility of attaining knowledge about the world [50,51]. Given the ontological and epistemological positions of critical realism in the current study, the researcher is inevitably separated from the subjectivity of the participants experience and the interpretative paradigm outlined throughout the methodology describes how this separation and subjectivity is accounted for.

2.1.2. Theoretical & Philosophical Background of IPA

IPA is informed by its philosophical foundations in phenomenology, hermeneutics, and idiography [47]. IPA informed by phenomenology, which maintains a commitment to understanding the individual's first-person lived experiences, and acknowledges subjectivity in the way individuals are situated in a particular context, for further exploration of phenomenology and its role in IPA see Smith et al. [47,52].

IPA is also informed by hermeneutics, the philosophical theory of interpretation. Hermeneutics accounts for the inevitably interpretative and subjective nature of IPA due to the gap between the participants descriptions and the researcher's interpretation of them. Gadamer identifies the role of horizons, whereby the interpreter's context is projected onto the object of analysis, highlighting the role of context and preconceptions in influencing both the researcher and the participants interpretations of their own experiences [53]. As a result, the position and context of the researcher is made transparent in the reflexive statement (See Appendix A for Reflexive Statement). Hermeneutics is primarily applied to IPA through the hermeneutic circle. The hermeneutic circle refers to an iterative process of understanding, moving cyclically between the parts and the whole of the participants experience, whereby an understanding of the parts informs an understanding of the whole, and an understanding of the whole informs an understanding of the parts [53,54]. This was applied to the research in that each case was read, re-read, and analysed in isolation to understand each participants total and unique experience. In line with IPA methodology, analysis will then move from unique to shared experiences, investigating the commonalities between the cases [47]. By applying the hermeneutic circle, reflexive engagement with the transcripts can be informed via engagement with the wider research context, allowing the individual cases to then be revisited with greater depth.

IPA maintains commitment to an idiographic research focus, emphasising a detailed and in-depth exploration of the individual within their context. IPA seeks to understand how a phenomena is understood or experienced by particular people in their specific context, it is therefore opposed to nomothetic generalisations and avoids claiming universality of its research findings [47]. To achieve this, a small sample size of seven was attained, this sample size is consistent with IPA's emphasis on depth over generalisability, allowing for a detailed exploration of each participant's unique experience [47]. Furthermore, each interview was analysed individually before moving to a cross-conceptualisation of shared aspects of experience across the interviews. In addition to this, quotes from individual participants are presented alongside throughout the findings to maintain idiographic specificity. This idiographic focus was central to the interpretation of participants'

experiences and ensured that shared and unique experiences were addressed.

2.2. Participants

In total seven individuals participated in the study, corresponding to seven interviews. To participate in this study, participants needed to: identify as female; be aged between 10-20 (or in school grades 5-12); be currently or previously enrolled in mainstream education; and have a primary diagnosis of ADHD from a qualified healthcare professional. The age range and focus on mainstream education were chosen to capture a wide range of school experiences of female students with ADHD, a group that is underrepresented in extant research [45]. Participants who met the inclusion criteria were required to provide consent to participate in the interview. Participant demographics were collected to provide information about each participants' unique context (see Table 1), under their deidentified, chosen pseudonym. These demographic factors were collected to provide context for understanding how various aspects of participants' lives such as socioeconomic status and cultural background may influence their experiences of ADHD in the school setting [45].

Participant Pseudonym	**Caitlin**	**Amy**	**Hannah**	**Patricia**	**Lucy**	**Sarah**	**Elizabeth**
Age (Years)	10	11	12	13	14	17	19
Age of Diagnosis (Years)	8	8	10	11	10	17	14
ADHD Subtype	Combined	Inattentive	Combined	Combined	Combined	Combined	Inattentive
ADHD Severity	Severe	Moderate	Severe	Unknown	Severe	Unknown	Unknown
ADHD Medication	Yes	Yes	Yes	Yes	Yes	Yes	Yes
School Grade	5	6	7	7	8	11	Graduated
Family Composition	Two Parents	Two Parents	Two Parents	Two Parents	Two Parents	Two Parents	Two Parents
Family Size	4	4	4	4	5	4	4
Ethnic Background	White/ Australian	White/ Australian	White/ Australian	White/ Aboriginal Australian	White/ Australian	White/ Australian	White/ Australian
Socioeconomic Status (Percentile)	91st	52nd	91st	48th	42nd	41st	93rd
Type of School	Intendent	Public	Independent	Independent	Independent	Public	Public
Comorbidity	N/A	N/A	Autism Spectrum Disorder	N/A	Anxiety/ Phobia	N/A	N/A

Note: Socio-economic status is reported using Australia-wide percentile ranking of Postal Area Index of Relative Socio-Economic Advantage and Disadvantage, drawn from Australian Bureau of Statistics data from 2021 [55].

Table 1: Participant Demographic Summary

2.3. Recruitment

Recruitment for the current study was between May 2024 and September 2024. Participants were recruited through their parents. Ethics approval was received from The Human Research Ethics Committee at Macquarie University prior to the distribution of participation advertisements (Reference Number: #520241261657750). The study was deemed 'more than low risk' due to the involvement of minors and the sensitive nature of discussing personal school experiences, thus requiring additional precautions to protect participant wellbeing and anonymity. Due to the sensitive nature of the interview, protocols were put in place to ensure mandatory reporting decision trees were followed and provision of contacts for services if the interview evoked distress. Written and verbal informed consent was obtained from all participants and in the case of minors, from their parents as well.

Parents or older participants themselves contacted the researcher by email to choose a time to conduct the interview. Recruitment advertisements outlined the purpose of the study and gave the primary investigators contact information to inquire about participation. Participants were recruited through social media posts, posting the recruitment advertisement to the ADHD Australia Facebook and Instagram pages. Also, the advertisement was posted in various Facebook groups for Australian parents of children with ADHD, such as 'Parents for ADHD Advocacy Australia'.

Recruitment through social media and ADHD-related groups was chosen to ensure access to a diverse range of participants, who may not be as easily reached through more traditional recruitment methods. Additionally, the digital advertisement flyer was provided to clinicians to be passed on to parents of eligible children. Participants received a $30 online gift voucher to acknowledge the time and effort contributed by participating in the interview. This incentive was carefully balanced to avoid coercion, with it acknowledging participants' contribution without influencing their decision to participate or the content of their interviews [56].

2.4. Procedure

All seven interviews were conducted, and audio-visual recorded over the video meeting service, Zoom. In-person and online meeting options were provided to participants prior to interview scheduling. All participants chose to participate online via Zoom due to convenience. Zoom was chosen due to its accessibility and flexibility in scheduling, whilst facilitating the in-depth and conversational style required for IPA. Post-interview, Microsoft Word Online was used to transcribe each interview, each transcript was verified for accuracy in the participants phrasing, as well as pauses and non-verbal expressions, in addition to this the transcripts were de-identified with all identifying names and places redacted. In IPA capturing non-verbal cues and pauses is essential, as they often provide additional layers of meaning and insight into participants' understanding of their experiences [47]. Member checking was undertaken by emailing transcripts back to the participants or participant parents to provide the option to make any corrections or retract any statements. All participants or parents confirmed the final transcripts with no corrections or redactions. This process of verification is important in IPA as it ensures that the researcher remains as close as possible to the participants' own understanding of their experiences. At this stage participants were also asked to provide an anonymous pseudonym for inclusion in the study.

Interview recordings, transcripts, and completed consent forms were stored in a OneDrive folder under password protection. Once transcripts were verified by participants the recordings were deleted and only the de-identified transcript was kept, these were stored separately from the consent forms. Email exchanges with participants or participants' parents were deleted after transcript verification. The data was retained in the Macquarie Research Data repository. Separation of transcripts from consent forms was essential for protecting participant anonymity and ensuring that their identities were not traceable to the data.

After completion of the research participants were provided with a summary of the research including the aims, methods, and findings. Debriefing is especially important in research involving minors and sensitive topics, as it ensures participants feel informed and valued, while also reducing any potential distress from their involvement.

3. Materials

22 semi-structured interview questions were developed to address key aspects of the school experience and areas of interest such as classroom experiences, social experience, sources of ADHD psychoeducation, effective learning strategies, understanding of ADHD, strengths and challenges in school, perceptions of teachers, and understanding of the role of gender in ADHD. The interview questions were also devised by the authors, with the second author being a senior paediatric clinical neuropsychologist (see Appendix B for Interview Schedule). The interviews were conducted lasting 31-78 minutes in length with an average of 57 minutes across the seven interviews. The semi-structured nature of the interviews aligns with IPA's emphasis on flexibility, which allowed for a deeper, iterative exploration of participants' experiences and their associated meaning, whilst still addressing the core research question [47]. Whilst the interview schedule was followed for all interviews, the semi-structured approach allowed for clarification and follow-up regarding the participants' experiences.

3.1. Data Analysis

To apply IPA to the interview transcripts, the seven IPA steps outlined by Smith et al. reading and re-reading, descriptive analysis, exploratory noting and identifying experiential statements, devising subthemes, searching for connections and developing personal experiential themes, individual case analysis, and cross-case analysis to develop group experiential themes, were followed to ensure a rigorous and iterative approach to data analysis [47]. The data analysis process was inductive, avoiding prior expectations shaping the interpretations. This IPA process is completed for each participant individually, adhering to the idiographic nature of IPA (see Appendix C for Data Analysis Process). Additionally, given the hermeneutic circle, aspects of the process were iteratively revisited, and the analysis was refined for each participant. Credibility of interpretation was established in this process by ensuring agreement in the analysis, where the data was analysed by both the author and a trained research assistant, reaching consensus (see Appendix C for Data Analysis Process).

3.2. Validity and Reliability

Validity in IPA requires that the research maintains credibility and transferability as well as the extent to which the research is meaningful to the research question [57,58]. It was ensured that the recruited sample was adequate to address the research question by verifying that all participants met the inclusion criteria [58]. Credibility was ensured through participant verification and inter-rater checking of data with other team members, while transferability was achieved by providing a detailed description of participants' contexts [57,59].

Reliability in IPA was ensured by maintaining dependability and confirmability [60]. Dependability of the research process was ensured through the reflexive journal, maintaining a sufficient audit trail for decisions made throughout the analytic process [47,57]. Confirmability was ensured by grounding findings in the participants experiences, therefore direct quotations were provided within the research findings [57].

3.3. Methodological Integrity

Bracketing, a key process in qualitative research, was implemented to iteratively ensure that prior knowledge did not interfere with the interpretations of participants experiences [61]. This process is facilitated by a commitment to the participants verbatim descriptions of their experience, ensuring the researchers' input is limited. Utilisation of a reflexive statement and reflexive journal ensure awareness and transparency of potential sources of bias (See Appendix A for Reflexive Statement).

4. Findings

Consistent with IPA methodology, the results and discussion are presented together [47]. In line with Smith et al.'s IPA steps, three group experiential themes emerged from the data, each corresponding to an aspect of the participants' lived school experiences [47]. These group experiential themes were: (1) Being Understood and Self-understanding; (2) Navigating Autonomy and Support (3); Neurodiversity in Social Experiences. Each group experiential theme is constituted of group-level subthemes as shown in Figure 1. Additionally, participant quotations are presented with identifiers labelling the transcript page and line number. Whilst these group experiential themes are presented separately, they are inherently interrelated [47].

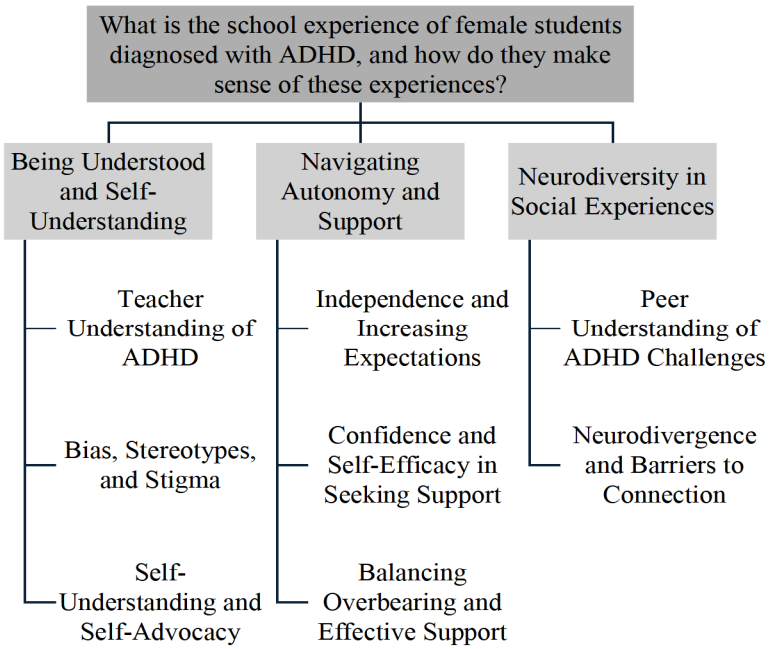

Figure 1: Group Experiential Theme Map

Group Experiential Theme 1: Being Understood and Self-Understanding

This group experiential theme encompasses the participants' shared desire to be understood by their teachers beyond stereotypes, bias, and preconceptions, as well as the necessity of self-understanding as a precondition for self-advocacy. This was constituted of three subthemes: (1) Teacher Understanding of ADHD; (2) Bias, Stereotypes, and Stigma; and (3) Self-Understanding and Self-Advocacy.

Subtheme 1.1: Teacher Understanding of ADHD

Throughout the interviews, all participants described a desire for greater teacher knowledge and understanding of ADHD, which they often saw as improving their learning experience and the quality of support they received. Teacher knowledge and self-efficacy surrounding ADHD have previously been demonstrated to be a key factor in providing effective classroom support [43,44]. Caitlin conveyed the way her learning experience and classroom engagement improved when her teachers tried to understand how she learns in: "*She's really good at understanding other students, and reading me" Caitlin, 9.282*. Conversely, Caitlin described frustration toward another teacher in: "*she did not understand me at all … she just doesn't understand what it's like to have ADHD" Caitlin, 9.306-314*. Our findings align with the educational ideal identified by Wiener and Daniels, whereby students with ADHD describe the benefit of teachers that are able to modify instruction, hold attention, minimize distraction, ensure understanding of class material, and better understand ADHD are preferred by students [6].

Moreover, greater knowledge of ADHD for teachers has been demonstrated to facilitate better contextualisation of students behaviour, informing greater empathy and more appropriate responses to behaviour [43]. In alignment with Ward et al., five participants described challenging classroom experiences resulting from teachers limited understanding of ADHD [43]. Amy described this by stating: "*when [the teacher] is explaining it, sometimes I draw … and then [the teacher] will get cranky and be*

like 'don't draw on the whiteboards! You're not listening!'... I'm like' I am listening ...I'm like thinking about it as I'm drawing.'" Amy, 18.421-426. Here, Amy demonstrated frustration toward her teachers' misunderstanding of her engagement, leading to a sanction-based response rather than accommodating what works for her. This aligns with other qualitative research, reflecting female students' experiences of limited teacher knowledge resulting in inappropriate, punitive or sanctions-based responses to ADHD-related classroom behaviour rather than being more accommodating [16,29]. Furthermore, Patricia described the benefit of teacher understanding in: "*He is the best teacher ever. He is amazing. He does everything to help me with my ADHD. He has fidget toys in his pencil case, for anyone who is struggling who would like a fidget toy." Patricia, 5.154-158*. Patricia's positive reflection and fondness toward this teacher reflects the way more accommodating and understanding teacher approaches are beneficial to engagement and positive teacher-student relationships.

Lucy Patricia, and Sarah also described experiences of teachers' stigmatised understanding of ADHD led to the participants being perceived as lacking intelligence and capability, resulting in their teachers providing patronising and overbearing support. Lucy recounted an upsetting and patronising experience with a teacher treating her as less intelligent and capable than her peers due to ADHD: "*she'd be very baby like to me and would never discipline me ... she'd just kind of treat me like a little child" Lucy,13.400-408*. This experience of othering by teachers relates to findings on greater knowledge of ADHD contributing lower levels of stigmatised beliefs about ADHD, as well as evidence of an ADHD diagnosis lowering teacher ratings of student performance, even when students are meeting grade-level expectations [44,62].

Additionally, Elizabeth and Sarah described the way the severity of their inattentive challenges were often not noticed by her teachers, Elizabeth attributed this to a lack of awareness about ADHD in: "*I would always get comments on my reports in primary school being like, oh she's always off in her own world…But I don't think anyone ever suggested that I could have ADHD" – Elizabeth, 3.113-116*. Corroborating findings of Lynch and Davison, where inattentive difficulties are often overlooked by teachers contributing to the under-detection and under-support faced by females with ADHD [16]. It also must be acknowledged that factors such as class size, teacher resources, and availability of learning support staff also contribute to these experiences of under-detection. Overall, this subtheme contributes to the growing acknowledgement of the importance of greater teacher education in supporting students with ADHD, as well as providing insight into the role of teacher knowledge in the stigma that female students with ADHD face in the classroom.

Subtheme 1.2: Bias, Stereotypes, and Stigma

School experiences of ADHD were also shaped by stereotyped and gender-biased beliefs surrounding ADHD, requiring females with ADHD to navigate the common male-dominant, stereotyped understanding of ADHD as "*the naughty, hyperactive boy" Sarah, 14.431*. Five participants described feeling their challenges were misunderstood, diminished, and often unseen due to their lack of alignment with the popular understanding of ADHD.

Amy described feeling unseen by popular understanding of ADHD as hyperactivity in:
[*ADHD is*] *more than just not being able to focus and like being hyperactive, it's more like how you think and like sometimes what you say." Amy, 22.507-510*. Similarly, Caitlin described the way stereotyped beliefs shaped the way peers and teachers perceived ADHD: "*a lot of people say that if you have ADHD, it means you're going to be more crazy" Caitlin, 5.152-153*. Caitlin conveyed frustration around these experiences, emphasising a desire for greater understanding for the severity of her challenges and desire for a more supportive response from teachers. Lynch and Davison highlight that teachers' adherence to androcentric, stereotypical views of ADHD, restricted to hyperactivity and externalising behaviours, often leads them to neglect of the inattentive or internalised challenges of females with ADHD [16].

Furthermore, Elizabeth described experiences of gender bias in how teachers responded to ADHD behaviours in the classroom, stating: "*Whereas if it's a girl or, in my experience, it's like, 'oh, you weren't paying attention, like, why weren't you paying attention?' ... it was kind of expected that [the hyperactive boys] weren't paying attention ... whereas for me it felt like I'd failed if I hadn't understood something" Elizabeth, 20.902-918*. These findings demonstrate the role of gender in behaviour appraisal, providing evidence that teachers underrate ADHD-related challenges in girls compared to boys exhibiting similar behaviours, as well as supporting previous research showing that hyperactive or disruptive behaviours are appraised as more severe in girls compared to boys [20,36]. This also highlights the role of gender-based, normative behavioural expectations in shaping teacher responses to ADHD-related classroom behaviour. However, some participants, particularly those from single-gender schools did not perceive differences in teachers' responses between boys and girls. This was only described by older participants, Elizabeth and Sarah, which may be a result of greater awareness of school-based gender biases arising later in development or in hindsight. Indeed, Neff et al. demonstrated that awareness of gender inequality for school-aged children increases with age [63].

Moreover, our findings suggest that participants' whose ADHD-related behaviour aligns more with the stereotypical male presentations of ADHD are more likely to face disciplinary responses form teachers as well as challenges with peers. Lucy attributed her challenges in class and difficulty relating to other female peers with ADHD to the way she violates gender-based expectations of ADHD and stereotypes of typical female behaviour norms in: "*In a way I have like ADHD that the boys have in my class, compared to what the girls have at my school, I'm very hyperactive" Lucy, 16.486-488*. This encapsulates the current subtheme, contributing to an understanding of how gender-based stereotypes surrounding ADHD and gender-normative classroom behaviour shape the school experiences of female students with

ADHD.

Subtheme 1.3: Self-Understanding and Self-Advocacy

For all of the participants, diagnosis and psychoeducation was described as increasing positive self-understanding, reducing feelings of guilt and self-blame toward challenges, as well as facilitating their ability to self-advocate. Within disability studies, self-advocacy refers to a component of self-determination, whereby individuals with a disability have sufficient self-knowledge, knowledge of rights, communication, and leadership skills to advocate their needs and autonomy [64,65]. The emphasis placed on self-knowledge in facilitating self-advocacy by Test et al., aligned with participants' experiences of needing to understand their own challenges prior to being able to seek help in class [65]. Hannah conveyed the role of self-knowledge in her challenging experiences communicating her needs to teachers, stating: "*Yeah. But I can't tell [my teachers] because I don't know how to explain that." Hannah, 21.648*. Further, these findings align with Mansfield and Soni, highlighting that difficulties with self-advocacy were often associated with greater negative self-stigma and feeling misunderstood [29].

Similarly, six participants described the way psychoeducation and increased understanding of ADHD reduced negative self-stigma and assisted them in navigating ADHD-related challenges. Amy described the benefit of psychoeducation in understanding and communicating her attentional challenges to her peers in: "*Mum explained it to me, she said people without ADHD… they'll have ten places to remember things. So, people [with ADHD], they might only have five so they can remember less things. So then that's when they get like big fidgety" Amy, 29.675-681*. For Amy, psychoeducation was empowering, allowing her to better understand and contextualise her challenges in a positive light, as well as communicate her needs to others. This aligns with the role of self-knowledge in not only reducing self-stigmatisation, but also promoting a greater ability to communicate needs in self-advocacy [65,66]. These findings also support the benefit of psychoeducation in improving academic outcomes and instigating behaviour change [67].

For Elizabeth and Sarah, social media contributed to reducing negative stigma and increasing self-understanding surrounding ADHD, where they benefitted from "*seeing that other people are experiencing the same things" Sarah,18.539-543*. Social media content contributed to learning about ADHD and "[realising] that it's not like a taboo thing" Elizabeth,18.796, which, for Elizabeth and Sarah, contributed to seeking an ADHD assessment and contextualising their challenges, aligning with Frondelius et al. [66]. Conversely, Amy described: "*There's only things that make me angry sometimes, [on Instagram]" Amy, 21.490*, describing frustration toward social media content that perpetuates stereotyped or reductive representations of ADHD. Whilst research on the role of social media is limited, these findings align with the mixed accuracy and portrayal of ADHD in social media content [68]. Additionally, this highlights the way in which social media can be beneficial for reducing stigma and contributing to ADHD assessment seeking. Overall, our findings highlight the prominent role of self-knowledge and sources of ADHD information in facilitating self-advocacy and reducing stigma for female students with ADHD.

Group Experiential Theme 2: Navigating Autonomy and Support

This group experiential theme encompasses participants' experiences surrounding needing and accessing support as well as growing expectations of independence and responsibility. This was constituted of three key subthemes: (1) Independence and Increasing Responsibility Expectations; (2) Confidence and Self-Efficacy in Seeking Support; and (3) Balancing Overbearing and effective support.

Subtheme 2.1: Independence and Increasing Responsibility Expectations

All participants conveyed challenges with keeping up with growing organisational, academic, and independence expectations. Failure to meet these increasing executive function demands often increased the salience of their challenges. For Sarah, difficulty managing the increasing academic and organisational expectations of Year Nine increased the salience of her executive function challenges, stating: "*I started just like being really bad at getting my school [work] done on time, like I started to like not really manage my time very well and like leaving things to last minute like a lot" Sarah, 5.157-159*. This experience can be conceptualised under Turgay et al.'s The ADHD Life Transitions Model, whereby development and change in the functional impairments of ADHD occur as a result of individuals finding it increasingly difficult to cope with growing executive function and independence demands placed on them as they progress through development [69]. These increased demands, alongside decreasing external support and parental involvement, can increase the severity and salience of ADHD-related challenges [69]. Within our findings this process increased the salience of ADHD-related challenges and for some contributed to seeking an ADHD assessment. In support of this, four participants described difficulty keeping up with their peers as teacher support decreased. For Amy, this was conveyed in her irritation toward her Year Six teachers' expectation of greater independence, stating: "*Sometimes I'll tell him that something is annoying me, or I don't get it, and he just will be like, oh well, you have to figure it out and he won't like help me as much" Amy, 7.146.*

Additionally, five participants described the way that learning academic organisational skills increased their confidence and independence in more challenging academic tasks. Patricia greatly benefited from this, saying; "*breaking down assignments do that! It's really good. I recommend that to everyone." Patricia, 12.366. Elizabeth describes the way a teacher who taught her organisational skills "made such a big difference" Elizabeth, 8.354*, thus increasing her confidence and self-efficacy in approaching larger assignments. Previous research has identified a moderate effect of organisational skills training in teacher rated academic performance, however our findings identified the role

of organisational skills training in promoting greater self-efficacy, academic confidence, and independence [70].

Elizabeth and Sarah described the way in which increasingly difficult organisational and academic expectations of high school, and the resultant increase in the severity of their challenges, contributed to seeking ADHD assessment and support. Whilst increasing challenges instigated seeking an assessment for Elizabeth, she also described the way in which her difficulty to meet academic demands was perceived as intentional disengagement rather than a challenge she needed assistance with. This was conveyed in: "*everyone was getting a bit more serious about studying ... like all the people that hadn't paid attention up until that point, like it was a choice that they were making, whereas for me it was like I was trying the whole time, and it wasn't really making a difference." Elizabeth, 7.288-291*. Whilst Elizabeth and Sarah were previously able to mask their difficulties, growing challenges instigated seeking out an ADHD assessment, providing an insight into the processes that contribute to ADHD diagnosis in girls. Similar experiences are reported in Morley and Tyrrell, highlighting the relationship between external demands and ADHD challenges. Our findings demonstrate the greater self-advocacy, and agency demands placed on females with ADHD due to their challenges often not being recognised by others, thus increasing the barriers to receiving a diagnosis and effective support [19].

Subtheme 2.2: Confidence and Self-Efficacy in Seeking Support

All participants described the way in which confidence and self-efficacy contributed to whether participants felt comfortable seeking out support in the classroom. Participants regularly described concern for being perceived as different or "*looking stupid" Elizabeth, 5.197*, in addition to lowered self-esteem due to ADHD-related challenges. This comparison to their peers was a significant barrier to participants seeking help and self-advocating aligning with other qualitative investigations of young people with ADHD [28,37]. All participants described these concerns about appearing incapable or standing out from their peers as preventing them from seeking help in class. Sarah described this lack of confidence in her ability compared to her peers, stating: "*It was really hard for me to learn stuff, it took me double the time to learn stuff than like everyone else" Sarah, 2.56-57*. Participants' confidence and likelihood to seek help in the classroom extends the aforementioned model of self-advocacy put forward by Test et al., suggesting that participants' low self-efficacy and concern for being perceived as different or incapable hindered their ability to self-advocate [65]. For Sarah, her lack of self-efficacy and confidence in class left her reliant on teachers approaching her to offer help, described in: *"I'll wait till they're walking around the class, because I don't want to be like, I don't understand any of what you just said in front of everyone" Sarah, 4.96-98*.

This experience was described by four participants, often relying on teachers coming to them to offer help rather than the students asking the teacher. Patricia conveyed this in: "*there's teachers who will come up to me and they'll be like, oh, do you need any help? And I'll be like 'what does this mean'? Or I'll be like, 'no, but thanks for asking though' and like they encourage me to ask them things." Patricia, 7.220-222*. Patricia's positive reflection on her supportive and attentive teachers reflected the way this classroom environment required less self-advocacy skills. Participants who did not have this classroom environment were required to develop and exercise greater self-advocacy. Similarly, Mansfield and Soni identified that students with ADHD who were capable of self-advocacy, but did not receive sufficient support often felt frustrated and that their challenges were diminished by teachers [29].

The effect of reputational concern or 'fitting in' preventing self-advocacy is exemplified by Elizabeth's description of the protective nature of academic self-efficacy, making her more comfortable to seek help, as conveyed in: "*Often, because I already knew like I knew more than a lot of my class ... I would be like 'oh it doesn't matter.' Like if they think I'm stupid for this one thing, it doesn't matter because they know I'm better at other things." Elizabeth, 6.236-238*. These experiences further support the dimensions of confidence and a desire to fit in as necessary for self-advocacy, in addition to factors of self-knowledge and knowledge of rights [65]. Whilst the benefit of individualised classroom support was identified as beneficial for all participants in keeping up with the teaching pace and the class content, this was not the norm across their school experiences. In different classes, participants felt more comfortable self-advocating their educational support needs in more supportive and receptive classrooms. They also felt more comfortable with seeking help and self-advocating their needs in more supportive classroom environments. That is, in environments where they felt their teacher would listen and understand their needs. This experience aligns with other qualitative investigations, highlighting the necessity of individualised support in promoting confidence and autonomy in self-advocacy [6,29]. Our findings suggest that confidence in help seeking and self-advocacy for female students with ADHD depends on a receptive, supportive, and non-judgemental class environment, ensuring students feel able to seek help.

Subtheme 2.3: Balancing Overbearing and Effective Support

Whilst all participants described the clear benefits of individualised classroom support, Sarah, Lucy, and Patrica described the way in which this support could become overbearing and undermined their autonomy and self-efficacy in the classroom, feeling like "*[teachers] treat [them] like [they're] not as smart as everyone else" Patricia, 14.413*. Self-Determination Theory, put forward by Deci and Ryan posits that failure to satisfy needs surrounding autonomy, competence and relatedness is associated with poorer motivation and well-being [71]. Within the school context, autonomy refers to young people's experience of learning and engaging as a volitional activity, as well as feelings of competence toward their ability to meet academic demands [72]. Rogers and Tannock, investigated self-reported perception of autonomy, competence, and relatedness in a mixed-gender sample of 117 children with and without ADHD and found that children with higher levels of ADHD symptoms reported feeling less competent in the classroom and experienced less support for their autonomy [72]. Similarly, our findings identify the need for a balance between

effective individualised support and overbearing support that damages students' ability to feel autonomous and competent. For Lucy, some teachers were able to provide positive and encouraging individualised support: "*She'll pay me more attention in class, and she won't just tell me to do stuff. She'll actually come over and sit down with me." Lucy, 7.189-190*.

Individualised support was often beneficial in building participants' academic self-efficacy, however participants also described how academic challenges combined with overbearing support could hurt their self-efficacy. An experience that often carried out in front of their peers. For Amy, an overbearing level of support made it difficult to develop her self-efficacy and made her insecure toward her own ability, also alienating her from her peers: "*I felt like she would like, really single me out as well. Like she would always give me like extra help, and I was kind of like, 'Why are you helping me?', 'I don't need help with this ... I'll tell you when I need help'" Amy, 25.573-577*. Amy's frustration encapsulates the balance that participants described between needing effective, individualised support, but simultaneously not wanting overbearing, patronising support that damages their autonomy and competence. This conveyed the participants' need for a secure base of support that they can access, when necessary. This finding corroborates the important role of agency, and an internal locus of control for students in seeking support, without undermining their self-efficacy [6,29]. Overall, our findings demonstrate that effective classroom support promotes student self-efficacy, self-advocacy, and autonomy without diminishing their competence and independence. Additionally, this highlights the ongoing, damaging role of classroom stigma and reputational concern that are barriers to girls with ADHD seeking support.

Group Experiential Theme 3: Neurodiversity in Social Experiences

This group experiential theme encompassed the way in which neurodivergence, the experience of having a mind that is different from typical, and its associated challenges contributed to the social difficulties that the participants experienced at school. This group experiential theme encompassed two subthemes: (1) Peer Understanding of ADHD; and (2) Neurodivergence and Barriers to Connection.

Subtheme 3.1: Peer Understanding of ADHD-Related Challenges

Five participants described the way peer understanding of ADHD and barriers to being understood by peers shaped their social experiences at school. For Caitlin this was expressed as discontent and annoyance toward not having friends who understood and shared her experience of ADHD: "*One of the annoying things about that is that since they don't have any ADHD, there's a lot of them that don't understand ADHD. So, they don't understand what it is." Caitlin, 8.229-237*. For Lucy and Patricia, being perceived as different by peers due to ADHD was described in difficulties with peer victimisation. Lucy described this challenging experience in: "*I have a few friends at school, most of them have moved schools, but it's not great. I get bullied a lot at school, so my social experience isn't amazing at school." Lucy, 13.377-378*. Whilst not all participants experienced this, our findings align with extant literature on the greater likelihood of peer victimisation for girls with ADHD [38].

Furthermore, Mikami highlighted that the greater likelihood of peer victimisation and other social challenges in females with ADHD may be a result of ADHD-related behaviours leading to greater departure from group norms or gender-normative behaviour [73]. Difficulty masking ADHD-related behaviours and greater rates of externalising or hyperactive behaviours may impair their ability to fit in with female socio-cultural social expectations and lead to less peer acceptance [73,74]. Additionally, school-aged children's deviation from school-based socially normative behaviour has been demonstrated to reduce peer acceptance, Chang measured self-reported endorsement of statements of social norms and acceptance by peers in a mixed-gender sample of 4,650 middle school students in China [75]. Given that more externalised ADHD behaviours (such as hyperactivity and disinhibition) are more commonly associated with the presentation of ADHD in boys, the social challenges faced by participants could perhaps be attributed to violating gendered expectations of behaviour [5,42]. Conversely, for Elizabeth, Sarah, and Hannah, the benefits of having friends as key sources of support at school were described. Elizabeth described benefitting from friends who were understanding and willing to learn about ADHD in: "*all my friends were just, like no one judged anyone for having ADHD. And my friends, like, wanted to understand it and everything." Elizabeth, 17.754-756. Similarly, Hannah, described her friends as "[her] support guardians" Hannah, 3.90*. These more affirming, positive and protective social experiences together, with the challenges associated with peers who lacked understanding of ADHD highlight the prominent way in which peer understanding and gendered social expectations shape the school social experiences of girls with ADHD.

Subtheme 3.2: Neurodivergence and Barriers to Connection

For five participants in the study, neurodivergence was a central part of their school social experience, contributing to social exclusion and social conflict due to difficulty interpreting social situations, as well as cognitive and affective differences. Consistent with Eccleston et al., participants often described feeling different to those around them, explaining the way in which ADHD influenced how they see and interact with the world [37]. Even for participants who were proficient in masking their ADHD, they felt a key part of themselves was not fully understood by their friends. For Amy, difference from her neurotypical peers was encapsulated in the way ADHD shaped how she saw the world, an experience she felt her peers did not understand: "*It's more than just not being able to focus and like being hyperactive. It's more like how you think and like sometimes what you say. And it's mental, like it's not just, I don't know, like you can't sit still." Amy, 507-510*. For Lucy and Patricia, neurodivergence contributed to negative perceptions from peers as well as peer exclusion due to being seen as different. Lucy explained: "*I don't have a lot of friends at school because I'm like different and they struggle to understand like the way my brain is wired and understand why I do things differently. And like take*

one look at me and kind of say, oh, she's weird instead of actually getting to know me." Lucy, 4.118-121. This corroborates previous research identifying the way that peers of children with ADHD hold negative views toward ADHD-related behaviours [39]. These experiences also align with the reported increased social challenges of girls with ADHD compared to boys [17].

Furthermore, four participants described the way in which cognitive and affective differences attributed to neurodiversity contributed to their social challenges at school. Patricia described the way in which disinhibition and hyperactivity were often misinterpreted by her friends, resulting in disagreements, stating: "*I tend to like not think and like do stuff because I can't, like, put on the brakes and my friends don't really get that and it's very annoying" Patricia, 4.92-97*. Additionally, Patricia described annoyance toward the way that inattention was misinterpreted by friends as being disinterested: "*I'll be staring into space thinking ... and then I will accidentally ignore my friends, and then they'll think I'm mad at them" Patricia, 3.81-84*. In their qualitative interview study of 7 boys and 6 girls with ADHD (aged 14-19 years) in Sweden, Frondelius et al. identified social challenges and fears arising from a concern about peers finding out about their ADHD, fearing stigmatisation, bullying, and exclusion [66]. Whilst participants in the current study faced stigmatisation toward their ADHD, it was less frequently from peers. Instead, social challenges with peers were more commonly described as misunderstanding of challenges or misinterpretation of ADHD-related behaviours, rather than overt stigma. Whilst there is limited research on the increased social challenges of girls with ADHD, Mikami described that this could be the result of ADHD leading to increased difficulty with emotional intimacy and social reciprocity [73]. Attributes that are more commonly expected of female dyadic friendships, making it difficult for girls with ADHD to meet the social expectations of their peers [73].

For Caitlin, Amy, and Patricia, social challenges often related to difficulties with making new friends, and anxiety around existing friendships. Caitlin described this difficulty with instigating social connections in: *"I'm not that good at making friends. Like, if I was just to say hi to someone, they have to start the conversation otherwise we're not talking" Caitlin, 18.570-571*. Similarly, Amy described anxiety and insecurity with her social connections, stating: "*Sometimes I'll feel like they hate me. Like, I feel like sometimes people do stuff and I feel it's really targeted at me." Amy, 24.555-556*. Whilst extant research identifies increased social challenges with peer interactions for female children with ADHD, our findings highlight the role of additional challenges with social approach and social anxiety that shaped the participants' school social experiences [17].

Corroborating the findings of Frondelius et al., four participants described that they found it easier to be friends with other people with ADHD [66]. Hannah described neurodivergence as being "*like a magnet" Hannah, 8.234*. She further described how there was greater mutual understanding with her neurodivergent peers, finding that shared experience often facilitated greater connection, with "*most of [her] friends have ADHD" Hannah, 8.229*. Lucy also conveyed the benefit of more neurodiverse-friendly peers and environments, such as in her extracurricular drama class, stating: "*It's very neurodiverse ... I'll find it a lot easier to make friends at drama than I do at school because they're all understanding ... they know what I'm going through, because they go through it themselves" Lucy, 12.360-368*. Our findings contribute towards a greater understanding of the role of neurodiversity in how girls with ADHD not only relate to their peers but form an identity in reference to their diagnosis.

Our findings indicate a dual role of neurodiversity for girls with ADHD. That is, ADHD played a role in both shaping identity and in how they experience the world, often promoting connections with other neurodiverse peers, while also creating feelings of isolation, disconnection, and exclusion from peers. The prominent role of neurodiversity in shaping the school social experiences of girls with ADHD highlights the need for greater psychoeducation in schools to promote a more inclusive environment whereby neurodiverse students can feel more accepted and understood. Given that previous research has largely investigated adult women, our findings emphasise the need for further research to investigate the way in which diagnosis influences identity formation in girls with ADHD [46].

4.1. Strengths and Limitations of the Current Study

The current study has several strengths, including its utilisation of a wide age range compared to previous studies [6,29,66]. A wide age range allowed the research to cover a larger spectrum of the school experience, assessing students from years 5-12. Additionally, the wider age range captured the varying levels of insight and hindsight for different stages of development, with the advantage of both greater hindsight and developmental maturity in older participants. The study's utilisation of a qualitative IPA framework was also a strength, as it provided greater depth and detail than alternative qualitative methods. Focusing on females with ADHD provided an opportunity for an underrepresented population to contribute what is important to them [45].

The current study also had a number of limitations. Whilst there is no prescribed sample size required for IPA research, saturation is a common criterion for this, stating that the ideal sample size is reached when no new themes are arising from the data [76]. Whilst Smith et al. suggest that 6-10 interviews is sufficient for IPA, due to the time constraints of a slow recruitment process, saturation may not have been reached with our sample of seven participants [47]. A lack of saturation may have resulted in some key experiences and themes being omitted from the findings. An additional limitation was the lack of representation of female students from ethnically and culturally diverse backgrounds as well as diverse socioeconomic backgrounds. This remains a key area of underrepresentation in ADHD research [45].

Whilst gender is a key domain of underrepresentation in ADHD research, there remains limited acknowledgement of the intersecting role of race, class, socioeconomic status, gender, and

culture in influencing the complex experience of young people with ADHD and disability as a whole [45,77]. Without greater representation of these key aspects of identity our research may have been overly focused on the identity label of ADHD diagnosis, forgoing the other components of social identity that shape young people's experiences of education and disability [78,79].

Furthermore, this research recruited participants who had received an ADHD diagnosis, the majority of which received a diagnosis relatively early. This is likely not representative of the wider population due to the issues of non-detection and late diagnosis, with Skoglund et al. finding females were, on average, diagnosed with ADHD at 23.5 years of age [13]. Similarly, Mowlem et al. highlighted that externalising behaviours are a strong predictor of earlier diagnosis in females, often instigating earlier diagnosis than inattentive symptoms [24]. Given our sample consisted of five out of seven participants presenting with the combined subtype of ADHD, our sample may not be fully representative of the wider population of females with ADHD, and specifically the experiences of those who go undetected until adulthood due their predominantly inattentive presentation of ADHD.

Another limitation was the potential for participants to have restricted their responses due to discomfort disclosing personal experiences to a stranger and group 'outsider', therefore limiting their answers throughout the interview. Finally, there are inherent methodological limitations in the researchers' ability to fully and empathetically understand the participants' experiences (see Appendix A for Reflexive Statement). IPA has inherent limitations due to the critical realist paradigm and the nature of interpretation. Whilst efforts were made to limit bias in the interpretative process through reflexivity and inter-rater analysis, the experiences of the participants remain inevitably subjective, and are a product of the researchers' context and horizons [53].

4.2. Implications and Future Research

The goal of the present study was to explicate the experiences of female students with ADHD, so that key areas of support and change could be identified, as well as highlighting key areas of future research. Firstly, our findings indicate a need for improved, formal teacher education surrounding ADHD, consistent with ADHD-Australia's submission to the 2023 Australian senate inquiry into barriers to assessment and support for people with ADHD [80]. Based on our findings, teacher training should be centred around psychoeducation of ADHD, classroom intervention and support strategies, and implicit bias training, as well as how ADHD presents across diagnostic subtypes and gender. Increasing teacher skills in knowledge of ADHD and it's presentation, including gender-based differences, would be beneficial for reducing stigma, improving classroom engagement, and reducing the non-detection of ADHD in females [44,62]. With this, future research would benefit from a qualitative investigation of teachers' understanding of ADHD in female students, providing insight into potential biased and stereotyped beliefs, as well as key areas of education and training. Additionally, given the limited diversity of our sample, future ADHD research should address the lack of representation outside of the dominant Western, Industrialised, Educated, Rich, Democratic samples in order to represent a wider and more diverse range of experiences [45,81]. Furthermore, improving psychoeducation for students with ADHD as well their peers would be beneficial to reduce stigmatisation and stereotyping that students experience in school, as well as assisting some children in identifying some of their own challenges that could be attributed to ADHD, as well as promoting self-advocacy. Additionally, greater education surrounding lifestyle organisational and time management skills may also benefit students based on our findings.

5. Conclusion

The current study provided insight into the experiences of female students diagnosed with ADHD in the Australian school context. The findings of this study highlighted the complex and challenging experiences faced by female students, these encompassed: experiences of poor teacher understanding of ADHD, biases and stigma, and a desire to be better understood by teachers and peers; factors contributing to the provision and accessibility of effective support, as well as factors involved with promoting agency and self-advocacy and the role of neurodiversity in social experiences. The findings highlighted the need for improved teacher education surrounding ADHD and the need for improved school-based ADHD psychoeducation. Further research is needed to extend our understanding of the factors contributing to under-detection of ADHD in female young people, as well as how the efficacy and accessibility of school-based support can be improved for female students with ADHD.

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Appendix A: Reflexive Statement

Due to the position of critical realism and the phenomenological nature of interpretative phenomenological analysis, the interpretations and findings of this type of research are inherently influenced by the context, perceptions, and beliefs of the researcher.

As I am a 22-year-old, neurotypical, cisgender male studying at university, I am inevitably separate from the population I am researching. Given this separation from the participants' experiences, there may be potential biases or difficulty for me to fully, empathetically understand the experiences of the participants due to vast differences in our contexts and identity.

However, my difference and 'outsider' status may also be beneficial in limiting bias due to my lack of shared identity and experiences with the participants. Therefore, reflexivity will be implemented to reduce the potential sources of bias in the research. To iteratively engage with and identify potential sources of bias, I maintained a reflexive journal to document areas of bias that arose during the analysis as well as logging the process and progress of my qualitative analysis. This journal allows me to log and reflect upon my subjective responses to the data, interview, and analytic [57,82]. I utilised this journal to develop analytical insights during the data analysis process and reflect on any pre-conceived ideas, as well as reflect on sources of bias and emotional reaction that may arise throughout analysis, this ensured that bracketing could be properly undertaken [82,83].

My epistemological and ontological perspective was informed by critical realism. By learning about critical realism, I was able to better formulate my understanding of the epistemological status of qualitative research, and the nature of the research findings. Critical realism acknowledges the existence of an ontologically *real* world, but the subjectivity of knowledge about the world, whereby knowledge about the world and experiences is filtered through our preconceptions, perceptions, and beliefs [48]. Given this, I am inevitably separated from the subjectivity of the participants experiences and the interpretative paradigm put forward by IPA and hermeneutics embraces this separation.

I am also influenced by the hermeneutic framework put forward by Gadamer and aim to apply the six hermeneutic steps of the hermeneutic circle, horizons, fusion of horizons, tradition and prejudice, language, and dialogue [53]. These six steps informed my understanding of the role I play in co-constructing knowledge with the participants by virtue of the interpretative process and the fusion of horizons. In addition to the implicit role of my own horizons in informing my interpretations and understanding throughout the IPA process.

Appendix B: Interview Schedule

Opening Remarks

Good [morning/afternoon/evening], [Student's Name]. Thank you for taking the time to join me for this interview. My name is [Interview Name], I am a researcher interested in understanding the school experiences of students with ADHD. During our chat, I will be asking about your time in school – what you enjoy, what has been challenging, any support systems you may have, and your interactions with others. Please take your time when sharing; It's important to that you feel comfortable expressing your honest experiences, you can skip any questions you don't want to answer. Our chat will be recorded to review later, but your name or any details that could point directly to you will be removed. Is that okay with you?

Additionally, this conversion will be made completely anonymous, any names, places, or details you mention will be removed from the final transcript. This chat is also completely voluntary and you're in control. Your well-being is a priority, so if at any point you feel uncomfortable, stressed, or have any concerns during our chat, just let me know, and we can adjust the question, take a break, or even stop the interview. If there is anything you share during out talk that you later wish to keep private or would like to discuss further, just let me know, and we can remove it from the final transcript. Before we get started to you have any questions you would like to ask? Feel free to ask me anything along the way as well.

Interview Questions

1. What is your overall experience at school?
a. Can you talk about your daily routine and activities at school?
b. What do you enjoy most at school?
2. What are the aspects of school life that you find particularly challenging?
3. Could you describe what ADHD means to you?
a. What do you understand about it?
4. What is it like to have ADHD at school? Could you describe your experience?
5. What are the aspects of school life that you find challenging?
a. How much do you think this is related to having ADHD?
b. How do you think this differs, if at all, with being a female with ADHD?
6. Do you take any medication as a result of your ADHD diagnosis?
a. How does this impact your experience at school?
7. Have you had teachers you felt were particularly effective at teaching you?
a. What did they do that you found helpful in your learning experience?
b. How did they support you in your learning?
8. Conversely, have you encountered teachers who were not as effective in teaching you?
a. Can you describe what made them less effective from your perspective?
9. Could you discuss some of the positives and negative experiences you've had with teachers at school?
10. Is there anything you wish every teacher understood about the way you learn as a female student with ADHD?
11. Is there anything you wish every teacher knew about ADHD to better support female students?
12. In terms of reading, writing, spelling (literacy), how do you find this area at school?
a. How much do you think this relates to your ADHD?
b. What strategies/things have helped you the most here?

c. What was not so helpful?
13. How do you find numeracy/mathematics (calculation, algebra and equations, measurement, and space, mathematical problem-solving, time)?
a. How much do you think this relates to your ADHD?
b. What strategies helped the most here?
c. What was not so helpful?
14. In terms of classroom support, have you received any specific interventions or strategies from your school or teachers to help support your learning?
a. What aspects of these strategies helped?
b. How effective have you found these?
c. Is there additional support you feel could have been beneficial?
15. In your experience, have you found any specific learning strategies or tools (e.g., organisation methods, note-taking techniques, technology) that have been particularly helpful?
16. What role has social media play for you in relation to your ADHD?
17. What is your experience with peers and social interactions at school as a female student with ADHD?
18. Do you feel like you are treated differently to your peers at all in class as a result of your ADHD?
19. What is your experience and interactions with teachers?
a. Are there any particular social situations or challenges you'd like to discuss?
20. Is there anything that you are concerned about for your transition to high school?
a. (If already above or in year 7) Is there anything you found particularly difficult in the transition to high school?
b. What are you looking forward to in relation to moving into high school? (If already above year 7) What did you find positive about transitioning to high school?
c. (If above year 7) Does your experience in high school differ to your experience in primary school?
21. How do you think males and females experience of ADHD differs?
a. What do you think differs in their experience at school?
b. How do you think their experience of social interactions differs?
22. Is there anything else you might like to add?

Closing Remarks

Thank you so much, [Student's Name], for sharing your thoughts and experiences with me today. Your insights are incredibly valuable for our research, and I appreciate your openness. As for the next steps, once I have transcribed our discussion, I will email it to you so you can have a read through, and if there is anything you would like removed or added just let me know. Before we finish, I want to check in on your experience. How did you feel about our conversation? Was there anything that made you uncomfortable or anything you would like to discuss further? If there is nothing else, you'd like to add or discuss, I want to thank you once again for your time and thoughtful participation. Take care, and if you ever have more questions don't hesitate to reach out.

Appendix C: Data Analysis Process

The seven IPA steps were adapted from Smith et al., including: reading and re-reading, descriptive analysis, exploratory noting and experiential statements, constructing subthemes or emergent themes, searching for connections across emergent themes and developing personal experiential themes (PETs), continuing the individual analysis of other case, and cross-case analysis [47]. These steps were undertaken in conjunction with measures to ensure the credibility of the data. The data analysis steps have been presented with example data extracts to illustrate each step.

1. Reading and Re-Reading

First, the printed transcripts were read and re-read to immerse the researcher in the data and focus attention on the participant's experiences. This stage also contributed to familiarising the researcher with the data.

2. Descriptive Analysis

Next, descriptive analysis took place, this step involved an empathetic summary of the participants experience to ground the analysis in the participants experiences.

Example: Elizabeth described a generally positive school experience; she spoke retrospectively regarding early challenges in learning and attention in primary school. Elizabeth describes how her ADHD symptoms were overlooked, with her only receiving an ADHD diagnosis in Year Nine at the age of 14. She described some challenges with teachers who she felt did not understand how she learns or who made her feel singled out or guilty for asking for help after becoming distracted. Elizabeth also described the stereotypical beliefs surrounding ADHD that led to her being undetected early on, as well as contributed to some of the stigma and minimisation she experienced during school.

3. Exploratory Noting and Identifying Experiential Statements (Identifying Concepts)

During this process initial exploratory noting took place, examining the semantic content and language use in the transcript, this involves highlighting of quotations with a comment pertaining to the descriptive, linguistic, or conceptual contents of the quote. These notes and quotations were compiled into experiential statements or 'concepts' corresponding to a quotation from the transcript and reflecting an aspect of the participants experience. Each quotation is given an identifier corresponding to the page and line number from the transcript.

Example: The concept of inattention as non-severe and the teacher misappraisal of challenges were drawn from Elizabeth description of the way her inattention wasn't acknowledged as a problem, and not recognised as potentially ADHD, in: "I would always get comments on my reports in primary school being like, oh, she's always off in her own world. Like she just like, isn't paying attention and like all this stuff. But I don't think anyone ever suggested that I could have ADHD." 3.113-116. Similarly, the concept of reputational concern was drawn from: "So it was like a constant battle of like is it worth looking stupid or like do I just deal with it and like not know half the stuff." 5.198-201.

4. Developing Subthemes (Emergent Themes)

The experiential statements, or concepts were then investigated alongside the transcript to identify patterns or connections, these experiential statements are grouped into emergent themes, often called subthemes, alongside a rationale to reflexively describe the reasoning for the grouping.

Example: From Elizabeth's interview, the concepts of *ADHD signs not acknowledged, ADHD was obvious in hindsight, frustration at overlooked challenges, teacher's lacked knowledge of ADHD, and some teachers were dismissive or unsupportive post-diagnosis*. These concepts were connected by the lack of symptom recognition in the classroom resulting from her teachers lacking sufficient knowledge to recognise her challenges. Additionally, this emergent theme captures the frustration and surprise that Elizabeth felt toward her challenges feeling obvious in hindsight, as well as her frustration toward having to recognise her own challenges at a young age.

5. Developing Personal Experiential Themes (Superordinate Themes)

Following this the emergent themes were explored in greater depth, identifying the connections and patterns between them and grouping them into superordinate themes or personal experiential themes. Generally, each participant structure results in two to three personal experiential themes. These personal experiential themes aimed to broadly summarise the key aspects of the participants experience. The exploratory notes, emergent themes, and personal experiential themes all constitute the final analysis structure for each individual participant.

Example: For Elizabeth one personal experiential theme was titled *Self-Understanding and Navigating the Representation of ADHD*. This encompassed the subthemes: *Lack of Recognition of Inattentiveness; Missed Diagnosis; Limited Awareness of Inattention and Hyperactive Stereotype; Impact of Misrepresentation and Minimization on Lived Experience; Role of Social Media in Diagnosis Seeking and Understanding ADHD; Online Misinformation Surrounding ADHD; Positive Outcomes of Diagnosis; Role of Gender in Help-Seeking; Cognitive Components of ADHD Experience; and Peers Hold Limited and Stereotyped Views of ADHD*. This personal experiential theme encompassed the way Elizabeth described challenges resulting from the public perception of ADHD as being limited to the hyperactive subtype, she described feeling as through challenges with inattention were missed or diminished due to misalignment with this view of ADHD. Additionally, she described role of social media as often spreading misinformation and generalisations about ADHD. Social media also played a role in reducing taboos surrounding ADHD and contributing to her seeking a diagnosis as it allowed her to contextualise the challenges she was facing at school.

6. Continuing Individual Analysis for Each Participant.

Each of these steps is completed for each participant individually and adhering to iterative nature of IPA and the hermeneutic circle, aspects of the process were revisited, and the analysis was refined for each participant.

7. Cross-Case Conceptualisation

Cross-case conceptualisation involved investigating the similarities and differences between the participants final analytic structures, comparing the personal experiential themes to identify shared and unique experiential themes. This process results in the formation of group experiential themes and constituent subthemes that communicate the overall experiences of the participants as a whole.

Example: The group experiential theme of *Being Understood and Self-Understanding*, was developed through personal experiential themes described by all participants. Each participant's final structure contained a personal experiential theme pertaining to a desire to be better understood by their teachers and peers, a desire for improved teacher knowledge, experiences of ADHD-related stereotypes and stigma, and the importance of self-understanding. These aspects were integrated to form the subthemes of the group experiential theme.

Credibility of Data Analysis

Credibility of interpretation was established in this process by ensuring agreement in findings where the data was analysed by both the author and a trained research assistant. The individual interviews were analysed and the findings were compared for agreement and discrepancies between the two raters, through discussion consensus was reached in interpretation, where agreement could not be reached a third-party (Second Author) was consulted until consensus in the analyses was reached [84].