Error, Oversights, and Delays: Exploring Mismedicine in Female ADHD Diagnosis

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Recognition of Attention Deficit Hyperactivity Disorder (ADHD) in girls and women has lagged behind for decades, leaving many to navigate childhood, adolescence, and early adulthood without an explanation for their struggles. Despite experiencing clinically significant symptoms, females are consistently diagnosed years later than males and often only after prolonged academic, social, and clinical difficulties (Agnew-Blais, 2024; Klefsjo et al., 2021; Skoglund et al., 2024). This pattern exemplifies what Dr. Pooya Beigi, founder of the Misdiagnosis Association and Research Institute (MARI), describes as mismedicine, which refers to the wide range of diagnostic, treatment, communication, and system-level errors that lead to preventable harm, inefficiency, or a failure to meet the standard of care (Beigi, 2019). Drawing on relevant literature and Dr. Beigi's insights, this paper will examine why women and girls experience delayed ADHD diagnosis and treatment, its consequences, and the evidence-informed interventions that can reduce this form of mismedicine.

Delayed Recognition of ADHD in Women

ADHD is a neurodevelopmental disorder indicated by problems with attention and/or hyperactivity-impulsivity, usually distinguished between presentations of either predominantly inattentiveness, predominantly hyperactive-impulsiveness, or a combination of both (Young et al., 2020; Young et al., 2024). Delayed recognition of ADHD in females is best understood as a diagnostic error that reflects systemic shortcomings rather than occasional oversight. As Dr. Beigi explains, errors can occur at many stages of the healthcare process-from initial information gathering to documentation and prescription handling-making diagnostic pathways vulnerable to even minor gaps that can contribute to delayed or inaccurate diagnoses (Blissy, 2024). Under the notion of mismedicine, late recognition is not a single missed opportunity, but a sequence of linked errors rooted in biased symptom expectations and poor communication across education and healthcare contexts (Beigi, 2019; Cortese et al., 2016; Young et al., 2020). These combined factors allow diagnosable impairment to go untreated.

Presentation, Prevalence, and Impact

Girls and women often present on the inattentive side with quieter, more internalized symptoms, such as daydreaming, emotional dysregulation, and social masking strategies due to gender norms that can hide functional impairment (Holden & Kobayashi-Wood, 2025; Martin, 2024). These behaviours are less disruptive than typical hyperactivity, therefore attracting less attention from teachers, caregivers, and primary-care clinicians (Cortese et al., 2016; Skoglund et al., 2024). Moreover, common assessment practices and diagnostic criteria were designed based on how ADHD typically appears in males, resulting in a stereotyped profile that may overlook females whose symptoms differ from that standard (Attoe & Climie, 2023).

Population-level evidence shows these mechanisms have measurable effects. In a large Swedish sample, Skoglund et al. (2024) reported that females receive their first recorded ADHD diagnosis

roughly four years later than males, despite extensive prior healthcare contact, suggesting repeated missed opportunities for detection. Clinical process data show how long the diagnostic pathway can be, where one study found that the average time from a first clinical visit to receiving an ADHD diagnosis was nearly three years, with girls requiring more visits before a diagnostic decision was made (Klefsjo et al., 2021). These are interconnected failures, where early missed recognition sets off cascading treatment and system errors that amplify harm over time (Beigi, 2019). Understanding these drivers of delay lays the foundation for examining the substantial real-world consequences that follow.

Consequences

Delayed or absent treatment after a late diagnosis carries tangible clinical, social, and economic consequences. Women diagnosed later typically have greater psychiatric complexity at the time of identification, including elevated rates of anxiety, depression, and emotional dysregulation, which can obscure ADHD and complicate assessment (Attoe & Climie, 2023; Young et al., 2024). Many are initially treated for those co-occurring conditions, leading to prescriptions for non-ADHD medications and needing more pre-diagnosis clinic visits, increasing healthcare utilization and the probability of polypharmacy (Attoe & Climie, 2023; Klefsjo et al., 2021; Skoglund et al., 2024). These prolonged and misdirected pathways also have lasting personal costs. Holden and Kobayashi-Wood (2025) describe women spending years seeking help without receiving an accurate explanation, often internalizing their difficulties as personal failings rather than symptoms of an untreated neurodevelopmental condition. Qualitative accounts illustrate the impact, through academic and professional disruptions, strained relationships, and extended periods of self-blame before reaching an accurate explanation (Holden & Kobayashi-Wood, 2025). These widespread impacts underscore the need for proactive, coordinated approaches to improve early recognition.

Prevention and Solutions

Reducing diagnostic delays in girls and women requires coordinated action across clinical, educational, and system levels. Because diagnostic expectations reflect male-centred research and referral patterns, clinicians also need targeted training to recognize female-typical presentations to have comprehensive ADHD knowledge (Attoe & Climie, 2023; Young et al., 2020). Schools also play a critical role, as several analyses note that teachers and school staff often miss inattentive symptoms in girls, suggesting they should receive training and have clear referral pathways so educational signals of impairment lead to assessment (Klefsjo et al., 2021; Young et al., 2020). Furthermore, clear, detailed communication from patients is also essential. Dr. Beigi stresses the importance of sharing complete information with clinicians, which is particularly critical for women who may mask symptoms due to social norms (Blissy, 2024; Holden & Kobayashi-Wood, 2025). Openly describing these challenges can streamline the diagnostic process.

Conclusion

Delayed diagnosis of ADHD in girls and women reflects a systemic pattern of mismedicine in which biased symptom criteria, ineffective screening practice, and structural barriers collectively set back treatment. These delays have substantial impacts, leading to more complex presentations at diagnosis and long periods of unaddressed symptoms that restrict everyday functioning and well-being. Practically, this means clinicians and educators need specialized training and stronger acknowledgement of relevant gender differences to minimize the diagnostic gap and preventable harm. Future research can aim to explore the most effective strategies for quicker recognition of ADHD in women and girls. Reducing these hidden delays will improve individual outcomes and lessen the errors that characterize mismedicine.

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