

Female Adult ADHD Scale-40 (FAAS-40)

Expanded Preliminary Psychometric Evaluation

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Abstract

ADHD in women may be under-recognised where difficulties are less overt, internalised, or managed through compensatory strategies. The Female Adult ADHD Scale-40 (FAAS-40) was developed as a female-informed self-report measure of ADHD-associated experiences in adult women. This expanded preliminary psychometric evaluation analysed responses from 267 adult women recruited through general-interest Facebook groups. Internal consistency was high (Cronbach's $\alpha = .962$; McDonald's $\omega = .964$), with corrected item-total correlations from .479 to .719. The item matrix was suitable for factor analysis (KMO = .944; Bartlett's $\chi^2(780) = 6472.45$, $p < .001$). Parallel analysis supported two exploratory factors within a structure dominated by a strong general dimension. FAAS-40 scores correlated strongly with the six-item Adult ADHD Self-Report Scale ($r = .867$, $p < .001$) and differed significantly across self-reported ADHD-status groups, Welch's $F(3, 53.58) = 56.57$, $p < .001$. These findings support continued evaluation of the FAAS-40 as a coherent female-informed measure. They do not establish diagnostic accuracy, female specificity, clinical cut-offs, or superiority to established ADHD screening instruments.

Keywords: ADHD; women; adult ADHD; screening; psychometrics; female-informed assessment; FAAS-40

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental condition characterised by persistent difficulties involving attention and/or hyperactivity and impulsivity, accompanied by impairment across important areas of functioning. ADHD in girls and women has historically been underrepresented in research and may be less readily recognised when difficulties are less overtly disruptive (Hinshaw et al., 2022; Quinn & Madhoo, 2014; Young et al., 2020).

Reviews and expert consensus suggest that females with ADHD show, on average, greater prominence of inattentive and internalising difficulties and less overt hyperactive-impulsive or externalising behaviour than males. Less visible manifestations, referral biases, co-occurring difficulties and compensatory strategies may contribute to delayed or missed recognition (Hinshaw et al., 2022; Young et al., 2020). These observations do not imply a categorically distinct female form of ADHD. Rather, the expression, visibility and interpretation of ADHD-associated difficulties may influence whether they are recognised.

This distinction is important in relation to screening. Screening instruments necessarily select particular symptoms and frame them in particular ways. The World Health Organization Adult ADHD Self-Report Scale (ASRS), for example, was developed from DSM symptom criteria and its six-item screener was selected to optimise concordance with clinical classification (Kessler et al., 2005). It is an established and useful case-finding instrument, but a positive screen is not equivalent to a diagnosis (Hines et al., 2012).

There is also empirical reason to examine how screening items function across demographic groups. In a large British population sample, Zhang and Markon (2021) found gender-related measurement non-invariance for a subset of ASRS-6 items, with males tending to show lower endorsement thresholds than females. This does not invalidate the ASRS; rather, it illustrates why measurement and symptom framing across populations remain legitimate psychometric questions.

Adult ADHD-related impairment may also extend beyond the literal wording of core diagnostic symptoms. Emotional dysregulation has been repeatedly associated with adult ADHD. A meta-analysis of clinically diagnosed adults found substantially greater emotional dysregulation than in healthy controls and a significant association between ADHD symptom severity and emotional dysregulation (Beheshti et al., 2020). Emotional dysregulation is nevertheless not specific to ADHD and should not be treated as a diagnostic criterion in its own right.

Compensatory strategies are similarly relevant to the recognition of adult ADHD. Adults with ADHD symptoms report organisational, attentional, adaptive, external-support and avoidance strategies, although such strategies are not female-specific (Kysow et al., 2017). A female-informed measure may therefore attend to compensation and everyday manifestations without claiming that these experiences occur exclusively in women.

Developmental Rationale for the FAAS-40

The Female Adult ADHD Scale-40 (FAAS-40) was developed to represent ADHD-associated difficulties in adult women using recognisable examples of everyday functioning alongside cognitive, emotional, organisational and compensatory experiences. The intended contribution is female-informed symptom framing, not the proposal of a separate female ADHD phenotype.

Item generation was iterative and informed by ADHD literature together with clinical and lived-experience observations. The item pool deliberately contains several kinds of content: items close to established ADHD symptoms; broader functional manifestations of executive difficulty; compensatory and coping behaviours; and a smaller number of exploratory lived-experience items. Exploratory content was not assumed to constitute established diagnostic symptomatology.

Five conceptual areas initially helped organise item development: executive function and working memory; emotional experiences; organisation and daily functioning; impulsivity and hyperfocus; and compensatory/social coping experiences. These were developmental categories rather than validated psychometric subscales. The present analysis therefore examines the empirical structure of the 40 items rather than imposing the original five-domain organisation.

The development process should not be interpreted as formal content validation. In particular, the present pilot did not ask women whether FAAS-40 items were more relevant, recognisable or representative of their ADHD experience than conventional screening questions. That question requires direct investigation in a clinically characterised sample.

Present Study

The present study asks whether the FAAS-40 demonstrates sufficient preliminary psychometric coherence to justify further validation. Specifically, it examines internal consistency and item performance, empirical internal structure, association with an established adult ADHD screener, and differences in scores according to self-reported ADHD status. It does not test diagnostic sensitivity or specificity, establish clinical cut-offs, demonstrate female-exclusive symptoms, or test superiority to existing screening instruments.

Method

Study Design and Recruitment

A cross-sectional anonymous online survey design was used. Participants were adult women aged 18 years or older, recruited through posts placed in a range of general-interest Facebook groups that were not specifically focused on ADHD or neurodivergence. Recruitment sought responses from women with differing relationships to ADHD, including women reporting an existing diagnosis, women awaiting assessment, women who suspected ADHD, and women who did not identify as having ADHD. Further demographic characteristics were not available in the survey dataset.

The expanded dataset comprised 267 respondents. Of these, 22 (8.2%) reported an existing ADHD diagnosis, 18 (6.7%) reported that they were awaiting ADHD assessment, 146 (54.7%) suspected that they had ADHD, and 73 (27.3%) reported neither an ADHD diagnosis nor suspicion of ADHD. Eight responses (3.0%) were otherwise unclassifiable. ADHD status was self-reported and was not independently verified.

Procedure and Ethical Considerations

Data were collected using Google Forms. Participants were adult women aged 18 years or older. Participation was voluntary and anonymous, and no identifying information was collected. Participants provided consent electronically before completing and submitting the survey. The study documentation records that the work was conducted as minimal-risk research with reference to the ethical principles of the British Psychological Society. The original materials do not document an institutional research-ethics committee approval number or formal waiver; the author should therefore confirm the applicable approval or waiver status in the journal title-page declarations before submission.

Measures

Female Adult ADHD Scale-40

The administered FAAS-40 comprised 40 frequency-rated items. The intended response scale was Never (0), Rarely (1), Sometimes (2), Often (3), and Always (4), giving a possible total score of 0–160. The exact administered item wording is reproduced in Appendix A.

The survey data export contained minor response-format anomalies. “Occasionally” was treated as equivalent to the second response category (score 1), and “Always.” as equivalent to Always (score 4). Where an exported response contained multiple selected response options, the numerical scores for all selected categories were averaged. These harmonisation rules produced complete scores for all 267 respondents across the 40 FAAS items. The FAAS-40 total score was the primary scale score.

Adult ADHD Self-Report Scale

The six ASRS screening items were included as an established ADHD screening comparator (Kessler et al., 2005). For correlational analysis, responses were coded from 0 (Never) to 4 (Very Often) and summed. Minor capitalisation and multi-selection anomalies in the export were harmonised using the same principle as the FAAS items. The ASRS-6 was used to examine convergent association, not as a diagnostic gold standard.

PHQ-9

PHQ items were present in the original survey; however, review of the data export identified an inconsistent response format for one item. The PHQ-9 was therefore excluded from the present reanalysis rather than carrying forward an uncertain total score or correlation.

Statistical Analysis

Analyses were reproduced in Python using NumPy 2.3.5, SciPy 1.17.0 and statsmodels 0.14.6. Descriptive statistics were calculated for FAAS-40 total scores. Internal consistency was evaluated using Cronbach's alpha, a one-factor McDonald's omega estimate, mean inter-item correlation, corrected item-total correlations and alpha-if-item-deleted values.

Factorability was evaluated using the Kaiser-Meyer-Olkin (KMO) measure and Bartlett's test of sphericity. Eigenvalues of the Pearson item-correlation matrix were inspected and parallel analysis used 500 random normally distributed datasets of the same dimensions, retaining factors whose observed eigenvalues exceeded the corresponding 95th-percentile random eigenvalues. A two-factor exploratory factor analysis was then estimated by maximum likelihood using statsmodels and rotated using oblimin oblique rotation. Because the items are ordinal, this structure is treated as exploratory; future validation should use ordinal/polychoric methods and independent confirmatory analysis.

Pearson correlation was used to quantify association between FAAS-40 and ASRS-6 totals. Differences across the four defined self-reported ADHD-status groups were examined using Welch's one-way analysis of variance because of unequal group sizes and variances. Cohen's d was calculated for selected contrasts with the No ADHD/suspicion group. The eight other/unclassifiable status responses were retained in whole-scale analyses but excluded from four-group comparisons.

Results

Descriptive Statistics

Across all 267 participants, the mean FAAS-40 total score was 94.49 (SD = 28.74), the median was 98.0, and observed scores ranged from 21.5 to 159.

Internal Consistency and Item Performance

Internal consistency was high: Cronbach's $\alpha = .962$ and one-factor McDonald's $\omega = .964$. The mean inter-item correlation was .397. Corrected item-total correlations ranged from .479 to .719. Alpha-if-item-deleted values ranged from .961 to .962, indicating that removal of individual items did not meaningfully improve internal consistency.

Factorability and Exploratory Internal Structure

The item matrix was highly suitable for factor analysis (KMO = .944). Bartlett's test of sphericity was significant, $\chi^2(780) = 6472.45$, $p < .001$. The first five eigenvalues were 16.65, 2.03, 1.53, 1.50 and 1.32. The first component alone accounted for approximately 41.6% of total item variance.

Parallel analysis supported retention of two factors: only the first two observed eigenvalues exceeded the corresponding 95th-percentile random eigenvalues. The rotated solution showed a broad first factor encompassing cognitive, emotional and internalised ADHD-associated experiences, while the second was more strongly characterised by practical organisational and everyday functional difficulties. Several items showed appreciable loadings on both dimensions. In view of the dominant first eigenvalue and cross-loadings, the two dimensions are treated as exploratory rather than established subscales; the FAAS-40 total score remains primary.

Association With ASRS-6

FAAS-40 total scores were strongly positively associated with ASRS-6 total scores, $r = .867$, $p < .001$. This is interpreted as convergent association with established ADHD symptom screening, not criterion or diagnostic validity.

Differences by Self-Reported ADHD Status

Table 1. FAAS-40 Scores by Self-Reported ADHD Status

Self-reported ADHD status	n	Mean	SD
Existing ADHD diagnosis	22	117.59	20.54
Awaiting ADHD assessment	18	117.22	16.92
Suspected ADHD	146	101.97	23.15
No ADHD/suspicion	73	67.27	23.23

Welch's one-way ANOVA indicated a significant difference across the four defined groups, $F(3, 53.58) = 56.57$, $p < .001$. The diagnosed and awaiting-assessment groups had almost identical mean scores. The suspected-ADHD group scored lower than these groups but substantially higher than the No ADHD/suspicion group. The diagnosed versus No ADHD/suspicion contrast was very large (Cohen's $d = 2.22$), as was the suspected-ADHD versus No ADHD/suspicion contrast ($d = 1.50$). These large contrasts provide strong preliminary known-groups evidence within this self-reported sample.

Discussion

This expanded preliminary evaluation indicates that the FAAS-40 functions as a highly coherent 40-item measure in this sample of adult women. Reliability was high, all items showed substantive positive corrected item-total relationships, FAAS-40 scores converged strongly with an established ADHD screener, and substantial differences were observed across self-reported ADHD-status groups.

Reliability and Scale Coherence

Cronbach's alpha and McDonald's omega were both approximately .96, and no individual item improved alpha meaningfully when removed. These findings support the coherence of the total score. High internal consistency does not, however, establish diagnostic validity or demonstrate that the item content is unique to women.

Internal Structure

The empirical findings do not support treating the original five developmental domains as established subscales. Parallel analysis favoured two retained factors, while the very large first eigenvalue indicated a strong general dimension. The rotated structure broadly distinguished internal/cognitive-emotional experiences from practical organisational manifestations, but cross-loadings were common. The most defensible current interpretation is therefore a primary FAAS-40 total construct with secondary exploratory structure.

Convergence With Established ADHD Screening

The FAAS-40 correlated strongly with the ASRS-6, indicating that the broader female-informed item set remains closely related to established ADHD symptom screening. This provides strong convergent evidence while remaining distinct from evidence of diagnostic accuracy; positive screening results do not necessarily correspond to diagnosis on full assessment (Hines et al., 2012; Chamberlain et al., 2021).

Known-Groups Findings

The score gradient across self-reported ADHD status was marked. Women reporting a diagnosis and women awaiting assessment had very similar mean scores, followed by women who suspected ADHD, with the lowest mean among women reporting neither diagnosis nor suspicion. The large effect sizes provide strong preliminary known-groups evidence. Because ADHD status was not independently verified, however, these groups cannot be treated as clinically confirmed ADHD and control samples.

Female-Informed Rather Than Female-Exclusive

The central conceptual distinction is that the FAAS-40 was developed for women without depending on the claim that its constituent experiences occur only in women. The literature supports attention to less overt presentation and compensatory strategies in women, while also showing that many ADHD-associated experiences and coping strategies occur across genders (Hinshaw et al., 2022; Kysow et al., 2017; Young et al., 2020). The rationale is therefore one of representation and framing.

A direct male comparison would be required to test sex or gender specificity. That is not the primary research question in this pilot. A more relevant next question is whether women with independently established ADHD judge the FAAS-40 wording to be more recognisable, relevant or representative of their lived symptom experience than conventional screening wording.

Limitations

The study has several important limitations. Recruitment was by convenience sampling through general-interest Facebook groups and participation was self-selected. ADHD status was self-reported and not clinically verified. The design relied on self-report, did not include an independent response-validity measure, and did not establish test-retest reliability. Overlapping neurodevelopmental or mental-health conditions were not comprehensively controlled, and several FAAS-40 experiences are transdiagnostic rather than ADHD-specific.

The exploratory factor analysis used Pearson correlations on ordinal items. Although the findings are useful for preliminary structure discovery, future work should use ordinal/polychoric methods and confirmatory analysis in an independent sample. Finally, the present study did not directly assess content validity from participants' perspectives and cannot establish that women find FAAS-40 items more representative than existing screening items.

Future Research

The next validation stage should recruit women whose ADHD status has been independently established using recognised diagnostic procedures, alongside an appropriately characterised comparison group. This would permit criterion-validity analyses, sensitivity and specificity estimation, predictive values, and empirically justified threshold investigation. Test-retest reliability, discriminant validity and independent replication of the factor structure should also be examined.

A complementary content-validity study should directly compare FAAS-40 and established screening items for relevance, recognisability, clarity, comprehensiveness, everyday representativeness and perceived symptom fit. Qualitative feedback should also ask women which important experiences are missing from existing measures. This would directly test the central proposition behind the FAAS-40 rather than infer it from psychometric coherence.

Conclusion

The FAAS-40 demonstrated high internal consistency, strong item performance, strong convergence with an established adult ADHD screener and substantial differentiation between self-reported ADHD-status groups in an expanded sample of 267 adult women. Exploratory analysis suggests a dominant general construct with secondary differentiation between internal/cognitive-emotional and practical organisational manifestations.

These findings support continued systematic evaluation of the FAAS-40 as a female-informed measure of ADHD-associated experiences. The next stage is independent clinical validation together with direct investigation of whether women find its item content relevant, recognisable and representative of their ADHD-associated experiences.

White Paper Status and Versioning This 2026 white paper supersedes the earlier FAAS-40 pilot white paper as the current public research report for the N = 267 dataset and expanded psychometric analysis. It should be cited as the current version. The findings are preliminary and do not establish diagnostic accuracy, clinical cut-offs, female specificity, or superiority to established ADHD screening instruments.

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Appendix A. Exact Administered FAAS-40 Item Set

The items below reproduce the wording administered in the N = 267 survey export. Google Forms export labels such as “[Row 1]” and incidental leading/trailing whitespace are omitted. Wording, including any grammatical or punctuation irregularities that were presented to respondents, is otherwise retained. Intended response options: Never (0), Rarely (1), Sometimes (2), Often (3), Always (4).

Table A1. Exact Administered FAAS-40 Item Wording

Item	Administered wording
1	I start tasks but rarely finish them without getting distracted
2	I frequently misplace necessary items (e.g., keys, charger, documents).
3	I forget tasks almost immediately after I'm told what to do.
4	I often need to re-read text because I lose focus mid-paragraph.
5	I lose track of what I was doing when interrupted.
6	I forget why I entered a room or picked up my phone.
7	I avoid tasks that require sustained attention.
8	I find it hard to follow multi-step instructions
9	I often feel guilt or shame for not “having it together and family often have to step in to support me with daily tasks.
10	I feel emotionally drained after ordinary social exchanges.
11	I ruminate excessively after awkward or emotional interactions.
12	I feel mentally paralysed when under stress.
13	I feel overwhelmed by tasks that others find manageable.
14	My mood shifts rapidly based on small external changes.
15	I can have intense reactions to perceived rejection leading to feelings of despair.
16	I experience emotional outbursts I later regret.
17	My home or workspace frequently fluctuates between very messy and briefly tidy
18	I forget what's in my fridge, pantry, or cupboard and overbuy the same thing.
19	I often leave shopping bags such as clothing I have bought or parcels unopened for days.
20	I create piles to “organise” but they become clutter.
21	I avoid cleaning or tidying because I don't know where to start.
22	I pay bills late even when I have the money, or conversely I pay them as soon as they appear before they need to be paid. .
23	I run out of essentials (e.g., toilet paper, milk) because I forget to replace them.
24	I often don't open important mail or emails.
25	I make impulsive purchases I later regret.
26	I hyper-focus on certain tasks and forget to eat, or respond to messages for hours.
27	I jump straight into relationships and then hyper focus on my partner, and I don't see red flags.
28	I drop hobbies within months of starting them.
29	I spend more time preparing for a task than completing it.
30	I impulsively reorganise or declutter and leave a bigger mess.
31	I often interrupt others unintentionally during conversations.

Item	Administered wording
32	I get “hooked” on ideas or interests and obsess over them temporarily.
33	I put in significant effort to appear organised or “normal.”
34	I use lists, systems, or set alarms or reminders to function daily.
35	I feel ashamed asking for help with basic life tasks.
36	I am often late, disorganised, or forgetful.
37	I’ve been told I “seem fine,” even when I feel overwhelmed.
38	I rely on visual reminders or alarms to function daily.
39	I hide my real level of chaos from friends, coworkers, or family.
40	I feel like I’m performing rather than being myself in professional settings, and often act like the clown.

Appendix B. Two-Factor Exploratory Loading Summary

Two-factor exploratory factor analysis using maximum-likelihood extraction and oblimin oblique rotation. Loadings are included as a transparent exploratory summary; the factors are not proposed as validated subscales.

Table B1. Two-Factor Exploratory Factor Loadings

Item	Factor 1	Factor 2
1	0.407	0.370
2	0.231	0.323
3	0.625	-0.005
4	0.676	-0.049
5	0.546	0.192
6	0.691	0.020
7	0.576	0.091
8	0.710	-0.043
9	0.676	0.080
10	0.853	-0.171
11	0.759	-0.087
12	0.665	-0.012
13	0.704	0.041
14	0.748	-0.100
15	0.733	-0.089
16	0.616	-0.054
17	-0.131	0.821
18	0.211	0.397
19	0.069	0.575
20	0.019	0.742
21	0.094	0.646
22	0.168	0.428
23	0.295	0.375
24	0.271	0.413
25	0.543	0.136
26	0.586	0.200
27	0.481	0.085
28	0.582	0.114
29	0.505	0.220
30	0.274	0.555
31	0.510	0.062
32	0.684	0.012

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Item	Factor 1	Factor 2
33	0.611	0.096
34	0.511	-0.004
35	0.453	0.307
36	0.406	0.359
37	0.477	0.166
38	0.547	0.157
39	0.382	0.417
40	0.621	0.093

Note. Maximum-likelihood extraction with oblimin oblique rotation. Factor signs are arbitrary and were oriented for interpretability. These exploratory factors are not proposed as validated subscales.