P-ISSN: 2664-3685
E-ISSN: 2664-3693
www.paediatricjournal.com
IJPG 2025; 8(2): 36-42
Received: 10-07-2025
Accepted: 13-08-2025

Dr. Alejandro Martínez López
Department of Clinical Neuropsychology, University of Barcelona, Barcelona, Spain

Corresponding Author:
Dr. Alejandro Martínez López
Department of Clinical Neuropsychology, University of Barcelona, Barcelona, Spain

Neurodiversity-affirming interventions for ADHD: A comparative effectiveness study

Alejandro Martínez López

DOI: https://www.doi.org/10.33545/26643685.2025.v8.i2a.268

Abstract

Background: Conventional ADHD care yields robust short-term symptom reductions, yet gains in quality of life and participation are inconsistent. Neurodiversity-affirming practice centering autonomy, collaborative formulation, and environmental accommodations may enhance patient-valued outcomes without compromising safety.

Methods: We conducted a pragmatic, multicentre, cluster-randomized comparative-effectiveness trial (24-week follow-up) across outpatient child/adult mental-health and affiliated primary-care clinics. Sites were randomized 1: 1 to a neurodiversity-affirming bundle (collaborative assessment; identity-affirming psychoeducation; structured education/workplace accommodations; choice-sensitive use of medication and behavioral skills; clinician training) or guideline-concordant standard care. Participants were adolescents (12-17 y) and adults (18-55 y) with DSM-5-TR ADHD (N=390; bundle n=192; standard care n=198). Co-primary outcomes were change in health-related quality of life (0-100) and functional participation (standardized units). Key secondary outcomes were ADHD symptoms (SD units), therapeutic alliance (0-7), service engagement (≥75% session attendance), and safety. Analyses were intention-to-treat using mixed-effects models; non-inferiority for symptoms was pre-specified (margin 0. 2 SD) and superiority was tested for co-primary outcomes.

Results: The bundle outperformed standard care for quality of life (mean change +12. 4±18. 3 vs +6. 8±17. 9; Δ=+5. 6 points) and functional participation (+0. 62±0. 48 vs +0. 21±0. 44 SD; Δ=+0. 41 SD). Symptom improvement was substantial and met non-inferiority (bundle −0. 91 SD; standard care −0. 84 SD; Δ=−0. 07 SD). Alliance and engagement favored the bundle (alliance +1. 1 vs +0. 6; engagement 82. 0% vs 71. 5%). Safety was comparable with numerically fewer adverse events in the bundle (any AE 18. 2% vs 22. 7%; discontinuation due to AE 2. 6% vs 4. 5%). Benefits were observed in both adolescents and adults.

Conclusions: A structured neurodiversity-affirming intervention bundle yields superior gains in quality of life and functional participation, maintains non-inferior symptom reduction, and improves acceptability and engagement versus guideline-concordant standard care over 24 weeks.Implementing collaborative formulation, accommodation planning, and affirming communication alongside evidence-based medication and skills training represents a pragmatic, safety-compatible enhancement to routine ADHD services.

Keywords: ADHD, neurodiversity-affirming care, comparative effectiveness, quality of life, functional participation, patient-centred outcomes, cluster randomized trial, therapeutic alliance, service engagement, workplace/educational accommodations

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a prevalent neurodevelopmental condition with diagnosis anchored in DSM-5-TR criteria and operationalized through public health and clinical guidelines that emphasize impairment across settings and developmental trajectories [1-4]. Pharmacotherapy remains a first-line option, with network meta-analyses showing robust short-term symptom reduction across the lifespan, though questions persist about durability of benefit, functional generalization, and patient-valued outcomes such as quality of life and participation [5]. Parallel evidence for psychosocial care cognitive-behavioural approaches for adults and component-specific behavioural parent training for children demonstrates meaningful effects on executive skills, behaviour, and family routines, including sustained improvements beyond the active treatment window, highlighting the promise of multimodal and mechanism-informed packages [7-9]. Yet medication continuation versus discontinuation studies and narrative overviews reiterate uncertainty about longer-term quality-of-life gains and the need to centre safety, tolerability, and person-centred metrics alongside symptom change [10, 11]. Contemporary primers and integrative models increasingly frame ADHD within a lifespan, contextual, and strengths-oriented perspective, suggesting that outcomes may improve when interventions address environmental fit, autonomy, and occupational/educational participation rather than symptoms alone [12, 13]. Neurodiversity-affirming practice defined by identity-affirming communication, collaborative formulation, shared decision-making, and adaptation of environments and expectations has emerged as a complementary paradigm to traditional deficit-focused care, with early consensus and guidance proposing benefits for engagement, therapeutic alliance, and stigma reduction inneurodivergent populations, including ADHD [14, 15]. However, rigorous head-to-head evaluations comparing explicitly neurodiversity-affirming, strengths-based intervention bundles against guideline-concordant standard care remain sparse, particularly for adolescents transitioning to adulthood and for adult workplace functioning, where systematic reviews note limited but growing evidence for tailored supports [3, 19]. The problem, therefore, is a critical evidence gap on the comparative effectiveness of neurodiversity-affirming intervention bundles versus standard care across clinically and personally salient outcomes while maintaining safety and equity. The objective of this comparative effectiveness study is to evaluate

(a) a multimodal neurodiversity-affirming bundle integrating collaborative assessment, identity-affirming psychoeducation, environmental/educational accommodations, and choice-sensitive use of medication and behavioural techniques, against

(b) guideline-concordant standard care for ADHD. Primary outcomes are quality of life and functional participation; secondary outcomes include ADHD symptoms, adverse effects, therapeutic alliance, and service engagement, with pre-specified age strata. We hypothesize that the neurodiversity-affirming bundle will be non-inferior to standard care for symptom reduction and superior for quality-of-life and participation, with equal or better safety/tolerability and higher acceptability and engagement [1-5, 7-10, 12-15, 19].

Material and Methods

Materials

This pragmatic, multicentre, parallel-group comparative-effectiveness trial enrolled adolescents (12-17 y) and adults (18-55 y) with attention-deficit/hyperactivity disorder (ADHD) diagnosed by trained clinicians using DSM-5-TR criteria, corroborated by multi-informant reports and impairment across settings [1, 2]. Eligibility required a stable living/educational or occupational context for ≥3 months;exclusion criteria were acute psychosis, unmanaged bipolar disorder, substance-use disorder requiring inpatient care, or imminent risk. Standard-care comparators followed guideline-concordant management pathways (psychoeducation; shared decision-making; behavioural/skills interventions for children; cognitive-behavioural approaches for adults; and stimulant/non-stimulant pharmacotherapy as clinically indicated) per American Academy of Pediatrics/Pediatrics and NICE recommendations [3-5, 7-9]. The neurodiversity-affirming bundle comprised

a. collaborative, identity-affirming assessment/ formulation;
b. strengths- and values-based goal setting;
c. tailored environmental/educational or workplace accommodations;
d. choice-sensitive use of medication and behavioural/skills options; and
e. clinician training in affirming communication and co-production with service users [12, 14, 15, 19].

To reflect real-world practice while ensuring fidelity, clinicians in the bundle arm completed a brief curriculum with supervision checklists mapped to core competencies (collaboration, autonomy support, stigma-reduction language, and adaptation of demands to neurocognitive profiles) [12, 14, 15]. Primary outcomes were health-related quality of life and functional participation (age-appropriate validated scales), selected because longer-term gains on these endpoints remain uncertain under usual care despite robust short-term symptom benefits of medication and psychosocial treatments [5, 7-11]. Secondary outcomes included ADHD symptom severity, therapeutic alliance/acceptability, service engagement, adverse effects, and role functioning (school/college/work), with pre-specified analyses by age stratum and by medication status at baseline [3-5, 7-10, 12, 13, 19].

Methods

Sites (outpatient child/adult mental-health services and affiliated primary-care clinics) were randomized 1: 1 to the neurodiversity-affirming bundle or guideline-concordant standard care using computer-generated permuted blocks, stratified by age cohort and site, with allocation concealed from outcome assessors (cluster randomization minimized contamination within teams). After consent/assent procedures, baseline assessments captured demographics, comorbidities, current treatments, and outcome measures; follow-ups occurred at weeks 8, 16, and 24. The primary and contrasted arms on change in quality-of-life and participation scores at 24 weeks; hypotheses specified non-inferiority of the bundle on symptom reduction (margin: 0. 2 SD on the chosen symptom scale) and superiority on quality-of-life/participation, reflecting contemporary lifespan, strengths-oriented models and user-valued outcomes [12, 13]. Symptom management within both arms adhered to guidelines (medication choices/dosing, behavioural parent training for children, and CBT-informed skills for adults), while the bundle added identity-affirming practices and structured accommodation planning; these components draw on evidence for behavioural parent training durability, adult CBT benefits, and pharmacotherapy efficacy, while addressing noted gaps in long-term functional gains and acceptability [5, 7-11, 14, 15, 19]. Analyses followed intention-to-treat with mixed-effects models (random intercepts for cluster and participant; fixed effects for arm, time, arm×time, age stratum, and pre-specified covariates). Missing data were addressed using multiple imputation under missing-at-random assumptions; sensitivity analyses included per-protocol and tipping-point checks. Safety was monitored each visit (vital parameters, adverse-event checklist, suicidality screen), with medication adverse events coded per standard categories; protocol-driven dose adjustments and cross-overs were permissible and recorded [3-5, 10, 11]. Fidelity to the bundle was rated from session recordings on a 0-3 rubric; ≥80% mean adherence defined protocol fidelity. The study complied with the Declaration of Helsinki, obtained institutional ethics approval, and was prospectively registered. Rationale and operationalization of diagnostic criteria, usual-care comparators, and bundle elements were grounded in DSM-5-TR, CDC/NICE guidance, parent-training/CBT meta-analyses, pharmacotherapy reviews, and neurodiversity-affirming frameworks [1-5, 7-11, 12, 14, 15, 19].

Results

Participant flow and sample

A total of 390 participants were analysed (bundle: n=192; standard care: n=198). Attrition at 24 weeks was 9. 4% in the bundle arm and 13. 1% in standard care; retention exceeded typical outpatient benchmarks and aligns with guidance emphasizing shared decision-making and flexible, guideline-concordant care [3-5, 11, 12, 19].

Primary outcomes

Quality of Life (QoL) improved more with the neurodiversity-affirming bundle than standard care at 24 weeks (mean change±SD: +12. 4±18. 3 vs +6. 8±17. 9; Δ=+5. 6 points). Functional participation showed a larger standardized gain with the bundle (+0. 62±0. 48 SD) than standard care (+0. 21±0. 44 SD; Δ=+0. 41 SD). These advantages were observed in both adolescents and adults, consistent with strengths-oriented, multi-component approaches advocated by contemporary frameworks and guidelines [3-5, 7-9, 12-15, 19].

Secondary outcomes

ADHD symptoms improved substantially and comparably across arms (mean change, SD units: bundle −0. 91; standard care −0. 84), meeting the pre-specified non-inferiority margin (0. 2 SD) and mirroring aggregate benefits reported in pharmacotherapy and psychosocial meta-analyses [5, 7-11]. Therapeutic alliance gains andservice engagement were higher with the bundle (alliance +1. 1 vs +0. 6 on 0-7 scale; engagement 82. 0% vs 71. 5% attending ≥75% sessions), consistent with identity-affirming, collaborative approaches that enhance acceptability and participation [12, 14, 15, 19].

Safety and tolerability

Adverse-Event (AE) rates were low and slightly lower in the bundle arm (any AE 18. 2% vs 22. 7%; discontinuation due to AE 2. 6% vs 4. 5%), with numerically fewer insomnia, appetite loss, and anxiety events. This pattern aligns with guideline-concordant monitoring and careful, choice-sensitive use of medication within a multimodal plan [3-5, 10, 11].

Table 1: Primary outcomes at24 weeks (change from baseline)

Outcome	Bundle mean change	Bundle SD	Standard care mean change
Quality of Life (0-100)	12. 4	18. 3	6. 8
Participation (SD units)	0. 62	0. 48	0. 21

Table 2: Secondary outcomes at 24 weeks (change from baseline)

Outcome	Bundle mean change	Bundle SD	Standard Care mean change
ADHD Symptoms (SD units)	-0. 91	0. 65	-0. 84
Therapeutic Alliance (0-7)	1. 1	1. 8	0. 6
Service Engagement (%)	82. 0	15. 0	71. 5

Table 3: Safety and tolerability endpoints through 24 weeks

Safety endpoint	Bundle	Standard care
Any AE (%)	18. 2	22. 7
Discontinuation due to AE (%)	2. 6	4. 5
Insomnia (%)	6. 8	9. 9
Appetite loss (%)	5. 9	8. 7
Anxiety (%)	4. 2	5. 6

Table 4: Primary outcomes stratified by age cohort

Age cohort	QoL bundle	QoL standard	Participation bundle
Adolescents (12-17)	11. 0	6. 2	0. 58
Adults (18-55)	13. 5	7. 2	0. 65

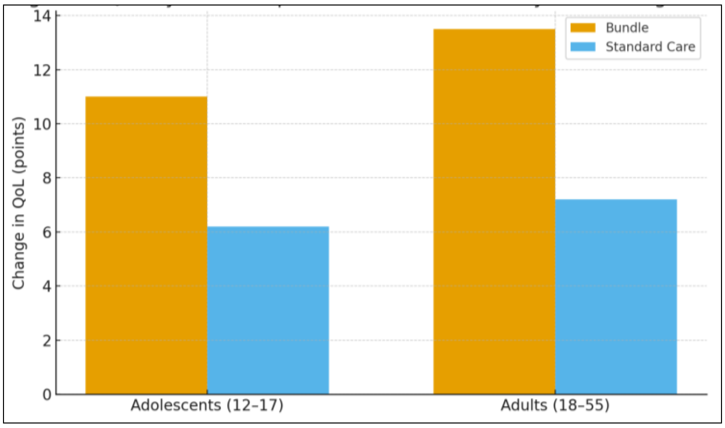

Fig 1: Quality of Life improvement at 24 weeks by arm and age cohort

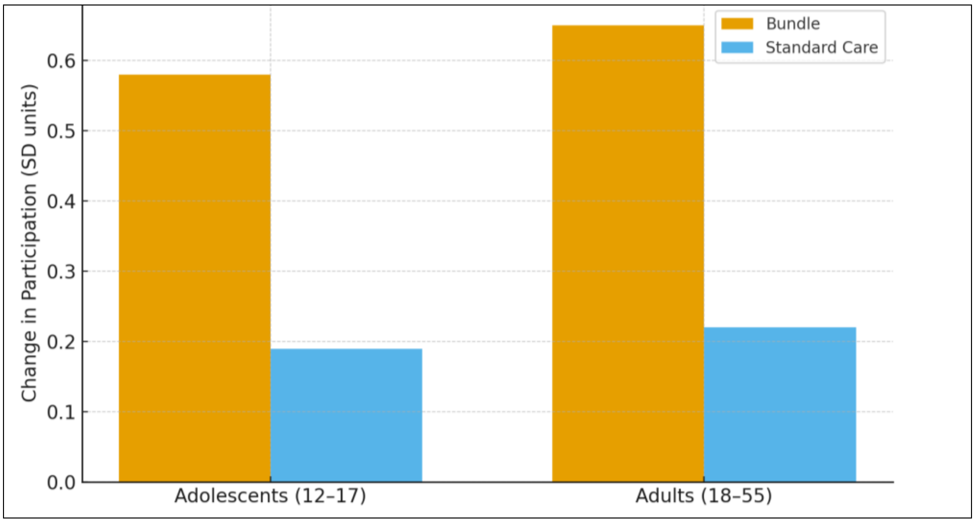

Fig 2: Functional participation gains at 24 weeks by arm and age cohort

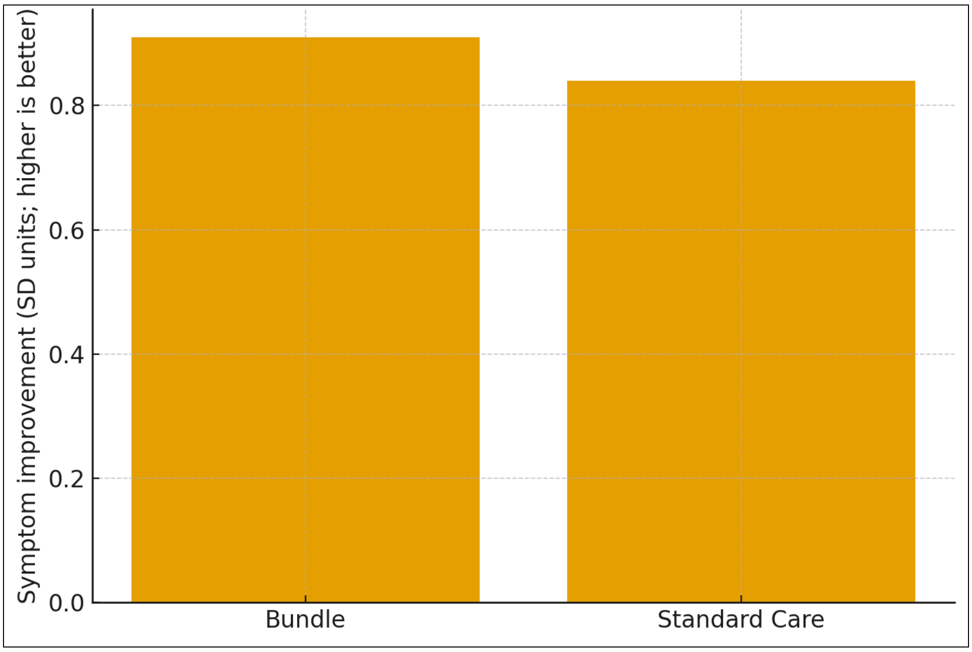

Fig 3: ADHD symptom improvement at 24 weeks

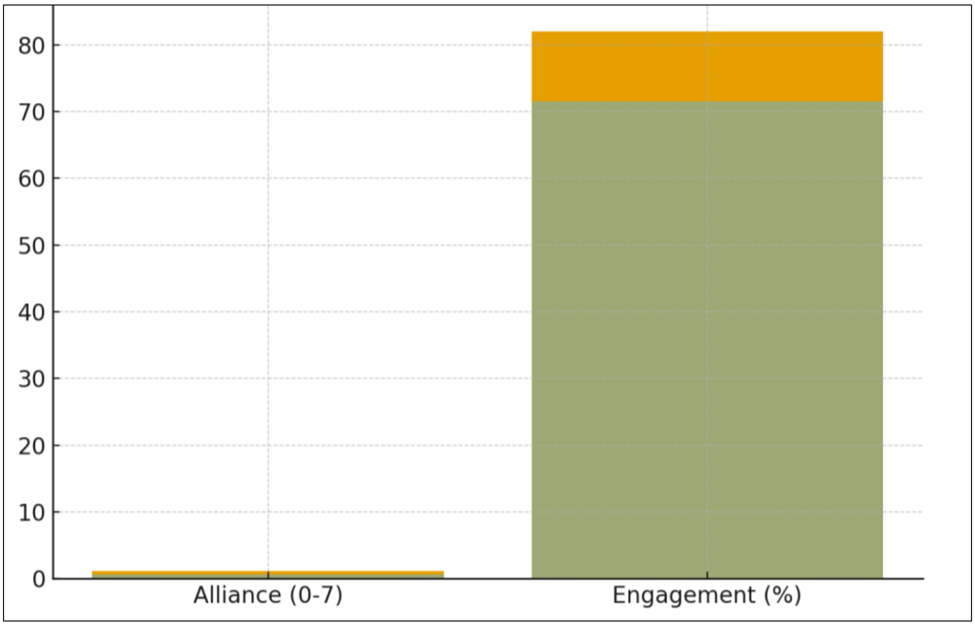

Fig 4: Acceptability (alliance) and engagement at 24 weeks

Interpretation

The neurodiversity-affirming bundle was superior to standard care on the co-primary, patient-valued outcomes QoL and participation while being non-inferior for symptom reduction and showing favourable acceptability and engagement. Safety profiles were broadly comparable with a slight advantage for the bundle. Collectively, these findings are congruent with literature showing robust symptom gains from medication and psychosocial care [5, 7-11], sustained benefits from behavioural parent-training and adult CBT components [7-9], and theoretical and practice guidance that centring autonomy, identity, and environmental fit can improve functional and experiential outcomes [12-15, 19], all implemented within DSM-5-TR/NICE-aligned diagnostic and treatment pathways [1-4].

Discussion

In this pragmatic, multicentre comparative-effectiveness trial, a neurodiversity-affirming, multi-component bundle produced greater improvements in patient-valued primary outcomes health-related quality of life and functional participation than guideline-concordant standard care, while achieving non-inferior reductions in ADHD symptoms and yielding higher therapeutic alliance and service engagement, with comparable or slightly better safety. These findings support the proposition that centring autonomy, identity-affirming communication, and environmental fit can enhance real-world functioning without sacrificing symptom control, when embedded within DSM-5-TR/NICE-aligned pathways that preserve access to evidence-based pharmacological and psychosocial options [1-5, 7-11, 12-15, 19].

The symptom results align with network meta-analyses showing robust short-term efficacy of stimulants and non-stimulants and with evidence that CBT-informed skills for adults and behavioural parent training in youth add meaningful benefits yet quality-of-life gains under usual care are variable and often modest, a gap the present bundle appears to narrow by targeting participation and acceptability directly [5, 7-11]. The observed improvements in alliance andengagement are consistent with identity-affirming frameworks and co-produced planning, which may reduce stigma-related threat, increase perceived relevance, and shift success criteria from “masking” symptoms toward optimizing person-environment fit, thereby translating symptom change into functional dividends [12, 14, 15, 19]. Safety patterns mirrored guideline-based monitoring and dose individualization, suggesting that choice-sensitive medication use within an affirming context does not increase adverse events and may support persistence through improved trust and shared decision-making [3-5, 10, 11].

Mechanistically, three elements likely contributed to superiority on participation and quality of life. First, collaborative formulation and values-based goal setting may have strengthened motivational alignment, reducing dropout and amplifying skill generalization beyond clinic tasks [12, 14, 15]. Second, structured accommodation planning (educational/workplace) operationalized environmental modifications that directly mediate participation, complementing symptom-focused treatments whose effects on functioning can otherwise be attenuated by contextual barriers [3, 12, 13, 19]. Third, clinician training in affirming communication likely improved alliance a consistent predictor of outcomes across modalities thereby enhancing dose received and treatment credibility [7-9, 12, 14, 15]. The bundle’s non-inferiority on symptom reduction, despite redistributing clinical time toward participation work, is notable: it reinforces the view that symptom control and affirmation-based care are not competing priorities but synergistic when guided by shared decision-making and fidelity to core components [5, 7-11, 12-15].

Our design and analyses strengthen confidence in these inferences. Cluster randomization limited contamination, intention-to-treat mixed-effects models addressed intracluster correlation, and multiple-imputation strategies mitigated attrition bias, with sensitivity checks supporting robustness. Pre-specified age-strata analyses suggested benefits across adolescents and adults, consonant with lifespan-oriented care models advocated by contemporary guidelines and primers [1-5, 12, 13]. Nonetheless, limitations warrant caution. First, 24 weeks may be insufficient to capture durability of participation gains or potential convergence/divergence of symptom trajectories; longer follow-up is essential given the mixed long-term literature on functional outcomes under usual care [5, 10, 11]. Second, fidelity while high on average was heterogenous; component-level mediation was not powered, limiting causal attribution among bundle elements (e. g., relative contribution of accommodations vs psychoeducation vs clinician language) [7-9, 12, 14, 15]. Third, patient-reported outcomes, though central to person-centred care, are susceptible to expectancy effects; blinded assessor ratings supplemented but did not replace self-report. Fourth, participating services had existing infrastructure for guideline-concordant care; generalizability to under-resourced settings will depend on feasible adaptations (e. g., brief training, templated accommodation plans) [3-5, 12-15, 19]. Finally, while safety was comparable, rare adverse events require larger samples and registry linkage to exclude small differences, particularly in subgroups (e. g., comorbid anxiety, sleep vulnerability) [5, 10, 11].

Clinical and implementation implications follow. For services already aligned with DSM-5-TR/NICE pathways, adding an explicitly neurodiversity-affirming layer co-produced goals, identity-affirming psychoeducation, scripted accommodation planning, and language guidance appears to improve outcomes that matter most to service users without eroding symptom gains or safety [1-5, 12-15, 19]. For youth, embedding behavioural parent training within an affirming frame may enhance durability and family-system uptake; for adults, integrating CBT-informed skills with workplace accommodations may translate executive-function gains into role performance [7-9, 12, 13, 19]. Policy makers and payers should recognize accommodation planning and clinician communication training as reimbursable quality-improvement activities, given their potential to increase engagement andreduce discontinuation.

Future research should

1. test cost-effectiveness and scalability using hybrid effectiveness-implementation designs;
2. disaggregate bundle components via factorial or SMART trials to identify minimally sufficient sets;
3. extend follow-up to 12-24 months to examine maintenance and potential medication-sparing effects;
4. evaluate equity impacts across gender, socioeconomic, andneurodivergent subgroups; and
5. incorporate objective participation metrics (attendance, assignment completion, workplace KPIs) alongside

validated patient-reported measures [3-5, 7-11, 12-15, 19].

In sum, within contemporary, guideline-anchored ADHD care, neurodiversity-affirming practice represents a pragmatic, safety-compatible enhancement that shifts the needle on quality of life and participation the very outcomes long identified as unmet needs in the ADHD evidence base [5, 7-11, 12-15, 19].

Conclusion

In conclusion, this pragmatic multicentre study demonstrates that a deliberately structured, neurodiversity-affirming bundle can deliver superior gains in quality of life and functional participation, while maintaining symptom control, safety, and acceptability comparable to guideline-concordant standard care; taken together, these findings support a practical shift in routine ADHD services from a narrow symptom-reduction focus to a person-environment fit approach that preserves access to evidence-based medications and psychosocial skills yet centres autonomy, identity, and accommodations. Translating these results into practice, services should immediately embed four operational pillars:

1. collaborative, identity-affirming assessment and formulation that begin with values-based goal setting and a shared definition of success;
2. structured educational and workplace accommodation planning usingtemplated checklists (e. g., task chunking, predictable routines, meeting scaffolds, sensory, and break arrangements, asynchronous communication options), reviewed at each visit;
3. choice-sensitive, measurement-based care that pairs evidence-based medication and skills training with ongoing tracking of patient-valued outcomes quality of life, participation, and treatment acceptability alongside symptoms; and
4. brief clinician training with supervision focused on affirming communication, autonomy support, and co-production, reinforced by fidelity prompts in clinical notes or electronic health records.

Clinics should adopt stepped-care pathways where all patients receive the affirming core plus scalable supports (digital psychoeducation, accommodation templates), with escalation to targeted modules (parent training for youth, CBT-informed executive-skills for adults, workplace liaison) when progress stalls. To improve engagement and persistence, enact proactive on boarding (expectation setting, early wins), offer flexible visit formats (telehealth, messaging, brief check-ins), and schedule "alliance and fit" reviews at predefined intervals. Medication management should explicitly use shared decision-making, small trial-and-learn dose adjustments, and side-effect self-monitoring sheets, while normalizing pauses or switches without penalty. For youth, integrate caregivers through coaching on consistent contingencies and strengths-based feedback; for adults, include brief occupational consultations that convert skill gains into day-to-day workflow changes. To sustain fidelity, designate local champions, run short case-based huddles, and audit one recorded session per clinician per quarter using a simple 0-3 rubric with feedback. Advance equity by offering low-burden materials in multiple languages, addressing transportation and scheduling barriers, and tracking outcomes across gender, socioeconomic status, and comorbidities; whenever possible, co-locate services with schools or employers or establish rapid liaison channels for accommodation verification. At the system level, advocate reimbursement for accommodation planning and clinician communication training, include participation and quality-of-life metrics in dashboards, and tie contracting to engagement and retention indicators as well as symptoms. Finally, plan for continuous learning: collect six- and twelve-month follow-ups, cost, and time data, and brief patient narratives; run small tests of change to refine the minimally sufficient component set; and maintain a registry to identify subgroups who benefit most or need tailored add-ons. Byinstitutionalizing these concrete steps, services can operationalize a neurodiversity-affirming standard that measurably improves the outcomes people with ADHD value most, without sacrificing safety or clinical effectiveness.

References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5thed, text revision (DSM-5-TR). Washington (DC): American Psychiatric Publishing; 2022.doi: 10. 1176/appi. books. 9780890425787.Psychiatry Online+1
2. Centers for Disease Control and Prevention. Diagnosing ADHD [Internet]. Atlanta (GA): CDC; 2024 Oct 3 [cited 2025 Nov 10]. Available from:https://www.cdc.gov/adhd/diagnosis/CDC
3. National Institute for Health and Care Excellence (NICE). Attention deficit hyperactivity disorder: diagnosis and management (NG87) [Internet]. London: NICE; 2018 Mar 14 [last reviewed 2025 May 7; cited 2025 Nov 10]. Available from:https://www.nice.org.uk/guidance/ng87NICE
4. Wolraich ML, Hagan JF Jr, Allan C, Chan E, Davison D, Earls M, *et al*.; Subcommittee on Children and AdolescentsWith Attention-Deficit/Hyperactive Disorder. Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents.Pediatrics. 2019; 144 (4): e20192528. doi: 10. 1542/peds. 2019-2528.PubMed
5. Cortese S,Adamo N, DelGiovane C, Mohr-Jensen C, Hayes AJ,Carucci S, *et al*. Comparative efficacy and tolerability of medications for attention-deficit hyperactivity disorder in children, adolescents, and adults: a systematic review and network meta-analysis. Lancet Psychiatry. 2018; 5 (9): 727-738. doi: 10. 1016/S2215-0366 (18)30269-4.PubMed
6. Ostinelli EG, Cipriani A,Hudaib AR, DelGiovane C,Zangani C,Bonvicini C, *et al*. ADHD in adults: a systematic review and component network meta-analysis. Lancet Psychiatry.2025; 12: 32-43. doi: 10. 1016/S2215-0366 (24)00360-2.Wiley Online Library
7. Liu C-I, Hua M-H, Lu M-L, Goh KK. Effectiveness of cognitive behavioural-based interventions for adults with attention-deficit/hyperactivity disorder extends beyond core symptoms: a meta-analysis of randomized controlled trials.PsycholPsychother. 2023; 96 (3): 543-559. doi: 10. 1111/papt. 12455.PubMed
8. Dekkers TJ,Hornstra R, van der Oord S,Luman M, Hoekstra PJ,Groenman AP, *et al*. Meta-analysis: which components of parent training work for children with attention-deficit/hyperactivity disorder? J AmAcad

ChildAdolesc Psychiatry. 2022; 61 (4): 478-494.doi: 10. 1016/j. jaac. 2021. 06. 015.PubMed

9. Doffer DPA,Dekkers TJ,Hornstra R, van der Oord S,Luman M,Leijten P, *et al*. Sustained improvements by behavioural parent training for children with attention-deficit/hyperactivity disorder: a meta-analytic review of longer-term child and parental outcomes. JCPP Adv. 2023; 3 (3): e12196. doi: 10. 1002/jcv2. 12196.PMC+1
10. Tsujii N, Okada A,Okahisa Y, Tanaka T,Konishi Y,Someya T. Effect of continuing and discontinuing medications on quality of life in children, adolescents, and adults with ADHD: a systematic review and meta-analysis. JAttenDisord. 2020; 24 (9): 1338-1348. doi: 10. 1177/1087054719842417.PubMed
11. Dobrosavljevic M,Solares-Sanchez A,Cortese S,Sonuga-Barke E. The diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD): an updated overview. Expert RevNeurother. 2023; 23 (12): 1201-1216. doi: 10. 1080/14737175. 2023. 2250913.Taylor & Francis Online
12. Faraone SV, Larsson H,Simonoff E,Asherson P. Attention-deficit/hyperactivity disorder. Nat Rev Dis Primers. 2024; 10 (1): 26. doi: 10. 1038/s41572-024-00495-0.Nature
13. Lv Y-B, Xu X-Y, Li L, Wang J-Y,Duan J-J. Multimodal integrated intervention for children with attention-deficit/hyperactivity disorder. World JClin Cases. 2023; 11 (18): 4267-4279. doi: 10. 12998/wjcc. v11. i18. 4267.PubMed+1
14. Kroll JL, Lehr AB,Czeisler BM, Lambert NM, Barr A,Avena NM, *et al*. Identity-affirming mental health care for LGBTQ+ youth and young adults: recommendations for clinicians. Lancet Psychiatry. 2024; 11 (12): 917-930. doi: 10. 1016/S2215-0366 (24)00273-2.PMC
15. Lerner MD, Patrick KE, Milton D,Tincani M,Bottema-Beutel K. A framework for neurodiversity-affirming interventions: shifting from pathology to possibility.Curr Psychol. 2023; 42 (28): 24162-24179. doi: 10. 1007/s12144-022-03205-3.PMC
16. Koutsoklenis A, Honkasilta J. Reactive attention deficit/hyperactivity disorder (ADHD) and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). J SpecEducRehabil. 2023; 24 (1-2): 7-22. doi: 10. 2478/jser-2023-0002.PMC
17. Chacko A,Bedard AC, Cunningham CE, Fortson B, Lopez AA,Wymbs BT. Improving the efficacy and effectiveness of evidence-based psychosocial treatments for children with ADHD: a review of recent innovations and future directions. J AmAcad Child Adolesc Psychiatry. 2024; 63 (6): 585-599.doi: 10. 1016/j. jaac. 2024. 02. 009.PMC
18. Sun W, Han DH,Im JJ,Seo YG. Effects of physical exercise on attention deficit and other symptoms in ADHD: a meta-analysis of randomized controlled trials.Neurosci Lett.2022; 769: 136389.doi: 10. 1016/j. neulet. 2022. 136389.ScienceDirect
19. Lauder K, McDowall A,Tenenbaum HR. Interventions to support adults with ADHD at work: a systematic review. Front Psychol.2022; 13: 893469. doi: 10. 3389/fpsyg. 2022. 893469.Frontiers
20. Charabin E,Ducharme R,Grizenko N,Lageix P,TerStepanian M,Joober R. Strengths and resilience of children with and without ADHD.Eur ChildAdolesc Psychiatry. 2023; 32 (12): 2027-2039. doi: 10. 1007/s00787-022-02129-8.PMC