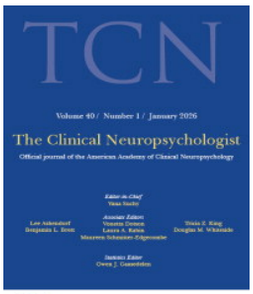

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AD/HD symptoms in assessment seeking post-secondary students: Has the COVID-19 pandemic made a difference?

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ABSTRACT

Objective: Anecdotally, individuals reporting symptoms of Attention Deficit/Hyperactivity Disorder (AD/HD) seem to have increased over the past few years, particularly since the onset of the Coronavirus disease 2019 (COVID-19) pandemic. As such, this study aimed to objectively investigate the validity of this observation. **Method:** Using archival data from 667 students assessed in a University-based clinic between 2018 and 2024, self-reported AD/HD symptoms on the Conners' Adult AD/HD Rating Scales–Self-Report: Long Version (CAARS–S:L) were compared across three time periods: pre-COVID ($n=407$), during COVID ($n=110$), and post-COVID ($n=150$). **Results:** Results indicate a significant increase in reported symptoms of inattention/memory, impulsivity/emotional lability, DSM-IV inattentive and hyperactive-impulsive symptoms, total AD/HD symptoms, and AD/HD index after the pandemic. Notably, there was a significant increase in problems with self-concept during and after the pandemic, and there were no significant changes in symptoms of hyperactivity/restlessness across all time points. However, the actual rate of diagnosed AD/HD in the sample did not significantly change across these periods. **Conclusions:** The findings support anecdotal observations and suggest that the pandemic may have exacerbated AD/HD-like symptoms in an assessment-seeking post-secondary population, even among individuals without formal AD/HD diagnoses. Increases in reported AD/HD symptoms may be related to COVID-19 pandemic factors such as heightened stress, disrupted routines, and increased screen time. The results underscore the need for careful diagnostic practices and further research on the impact of environmental factors on AD/HD symptomatology in young adults.

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Introduction

Neurodevelopmental disorders are a group of complex conditions that present early in childhood development. One of the most common neurodevelopmental disorders is Attention Deficit/Hyperactivity Disorder (AD/HD), a disorder characterized by

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symptoms of inattention, hyperactivity, and/or impulsivity (American Psychiatric Association [APA], 2022). The DSM-IV defined 3 main subtypes of AD/HD, based on different severities of symptoms in the dimensions of inattention and hyperactivity-impulsivity (Willcutt, 2012). The predominantly inattentive type (AD/HD-I) describes individuals with maladaptive levels of inattention without significant hyperactivity-impulsivity; the predominantly hyperactive-impulsive type (AD/HD-HI) describes individuals with maladaptive levels of hyperactivity-impulsivity without significant inattention; and the combined type (AD/HD-C) describes individuals with maladaptive levels of both inattention and hyperactivity-impulsivity (APA, 2013). To meet diagnostic criteria for AD/HD, symptoms of inattention and/or hyperactivity/impulsivity must additionally be chronic (present prior to the age of 12), pervasive (present in two or more settings), and cause impairment in terms of academic, social, or occupational functioning (APA, 2022). Finally, other causes for the reported symptoms must be ruled out (APA, 2022).

Typically diagnosed in childhood, AD/HD is thought to affect approximately 5.9–7.1% of school-aged children (APA, 2022; Willcutt, 2012). While AD/HD has long been considered to be a childhood condition, research suggests that, in many cases, AD/HD may persist into adulthood (Simon et al., 2009). However, research also shows that up to half of those diagnosed with AD/HD in childhood no longer meet the diagnostic criteria in adulthood (Caye et al., 2016). This decrease in cases may explain the lower prevalence rates of AD/HD, about 2.5–5%, reported in adulthood (Simon et al., 2009; Willcutt, 2012).

Over the past two decades, AD/HD diagnoses have been on the rise. In the United States (US), parent reported cases of AD/HD in children between the ages 4–17 years increased in prevalence from 7.8% in 2003 to 11% in 2011 (Visser et al., 2014). Worldwide data matched this trend, with an AD/HD prevalence increase from 5.29% in 2007 (Polanczyk et al., 2007) to 5.9–7.1% in 2012 (Willcutt, 2012), to 7.2% in 2015 (Thomas et al., 2015). Diagnoses of AD/HD in adult populations have also been increasing. Through a systematic review and meta-analysis of six studies published between 1996 and 2005, Simon et al. (2009) estimated that the pooled prevalence of adult AD/HD was 2.5%. Willcutt (2012) estimated that the pooled prevalence of adult AD/HD was 5.0% based on 11 studies published between 1996 and 2011. A subsequent systematic review of epidemiological studies that reported the prevalence of adult AD/HD in the general population from 2005 to 2019 estimated the prevalence of persistent adult AD/HD was 2.58%, and that of symptomatic adult AD/HD was 6.76% (Song et al., 2021). Data from the long running National College Health Assessment (NCHA) mirrors this trend; the number of Canadian university students who reported having ever received a diagnosis of AD/HD has risen from 3% in 2013, 4% in 2016, 6% in 2019 and 13% in 2022 (American College Health Association [ACHA], 2024). In reviewing a U.S. database of over three million patients diagnosed with AD/HD between 2010 and 2022, Russell et al. (2023) found that the incidence of adult AD/HD in their study population had tripled between 2010 and 2022, with the largest increase occurring between 2020 and 2022. Notably, these researchers identify that the main driver of this increase was a doubling of new diagnoses of females between 23 and 49 years of age during this time period.

Numerous reasons for these increasing rates have been posited, including increasing acceptance of neurodiversity resulting in more individuals seeking assessment, changes

in diagnostic criteria, and possible overdiagnosis due to inadequate assessment procedures (e.g., using self-report methods with weak psychometric properties, failing to rule out other possible causes, failure to obtain collateral information, failure to evaluate self-report credibility (Harrison & Pollock, 2025)).

The COVID-19 pandemic began in Canada in March 2020 and introduced unprecedented changes in daily life, including social isolation, increased screen time, disruption of routines, and heightened anxiety about health and future uncertainties (Abdel et al., 2022). Studies subsequently emerged regarding the impact of the COVID-19 pandemic on increasing symptoms of stress and distress in general, and symptoms of AD/HD in particular. For instance, Martinez and Nguyen (2020) found that the mental health of postsecondary students was negatively impacted in the first year after the onset of COVID-19 restrictions. Lanza et al. (2022) found that mental health problems such as anxiety and depression increased significantly in post-secondary students during the first year of COVID-19 relative to those experienced in the previous year. Linden et al. (2023) showed that Canadian postsecondary students experienced heightened levels of stress and psychological distress at the start of the pandemic, and these levels of distress remained high through the end of 2021. Data from the NCHA survey also demonstrates a marked increase in anxiety and stress beginning during the pandemic and continuing to affect the mental health of students: in the Canadian cohort, levels of self-reported anxiety rose from 12% in 2013, 22% in 2019, and then 32% in 2022. Similarly, the number of students reporting feeling overwhelming anxiety in the past 30 days increased from 52% in 2013, 69% in 2019, to 84% in 2022 (ACHA, 2024). Similar trends regarding increases in self-reported anxiety and stress since 2019 were also found in their data collected at American post-secondary institutions (Center for Collegiate Mental Health [CCMH], 2025)

It also appears that symptoms associated with AD/HD increased after COVID-19 restrictions began. For example, non-diagnosed children in a long-running cohort study began experiencing increased problems with concentration, attention, task engagement and persistence, and greater impulsivity during the first year of the pandemic relative to their measured behaviors pre-COVID (Raghunathan et al., 2022). Similarly, Son et al. (2020) surveyed 195 students with no prior history of problems and found that 89% now reported experiencing increased difficulty concentrating and paying attention and 86% reported having disrupted sleep patterns. Additionally, a study conducted in Japan found that university students reported a worsening of AD/HD behaviours during the pandemic when compared to before the pandemic (Takeda et al., 2023). This was particularly evident in female undergraduate students, with reports indicating that they were more susceptible to experiencing inattention symptoms during the pandemic (Takeda et al., 2023). Similarly, a study by Russell et al. (2023) reported that new AD/HD diagnoses have doubled in women aged 23–29 and 30–49 from the year 2020 to 2022. Anecdotally, this same trend has been observed by practitioners in our own assessment university-based assessment clinic and discussion with other practitioners suggests that we are not alone in noticing heightened reports of AD/HD symptomology during and post the COVID-pandemic.

In addition to individuals without preexisting AD/HD diagnoses showing symptoms of AD/HD, research shows that those with existing AD/HD diagnoses and symptoms also showed increases in self- and informant-reported symptoms. A study conducted

in Egypt found a statistically significant increase in parent-reported AD/HD symptoms in children and adolescents already diagnosed with AD/HD (Abdel Fattah et al., 2022). Additionally, a meta-analysis by Rogers and MacLean (2023) examined changes in AD/HD symptoms among children and adolescents with either subclinical or clinical levels of AD/HD symptoms before and during the COVID-19 pandemic. Drawing on data from 18 studies, the findings indicated an overall increase in AD/HD symptoms among children during the pandemic (Rogers & MacLean, 2023).

Thus, there remains a need for comprehensive, data-driven research to document and expand our understanding of this trend. In light of this, our study aims to provide concrete evidence on any changes to the presence and severity of AD/HD symptoms reported since the COVID-19 pandemic. To this end, this study compares data from three time periods: pre-COVID (January 2018 to March 2020), during COVID (March 2020 to September 2022), and post-COVID (September 2022 to current 2024) in an assessment-seeking population of post-secondary students. Based on available research evidence as well as clinical observation, we hypothesized that the number of reported symptoms increased during the pandemic and are yet to decline to pre-pandemic levels.

Methods

Participants

This study employed archival data collected from 1046 consecutively-assessed post-secondary students referred to a university-based regional assessment center for psychological or neuropsychological testing between 2018 and 2024 and who consented to their test data being used in ongoing research. As individual practitioners' assessment batteries differed based on the referral question, only cases where a measure evaluating self-reported AD/HD symptomology, namely the Conners' Adult AD/HD Rating Scales–Self-Report: Long Version (CAARS–S:L; Conners et al., 1999), were subsequently retrieved. An additional three cases could not be included in the current review as they were evaluated virtually during COVID lock down and did not complete more than the initial screening. Further, 196 cases were removed due to extreme inconsistency of responding (≥8) on the Conner's Inconsistency Scale. Although the assessment batteries administered routinely included additional measures of performance and symptom validity, participants were not removed for validity concerns as our primary interest was in analyzing self-reported AD/HD symptom scores rather than assessing validity. This left a total of 667 participants. These participants were separated into three groups: pre-COVID (between January 2018 and March 2020) consisting of 407 participants; during COVID (between March 2020 and September 2022) consisting of 110 participants; and post-COVID (between September 2022 and current 2024) consisting of 150 participants (see Table 1).

There was no significant difference in gender between groups X^2 (4) = 7.796, p = .099 (Cramer's V = .076). Additionally, there was no significant difference in mean age across the 3 time periods (pre-COVID: 22.05, during COVID: 22.35, post-COVID: 22.89), F(2,664) = .854, p = .426, with a very small effect size (η^2 = 0.003). Finally, there was no significant difference found in AD/HD diagnosis across groups X^2 (4) = .997, p = .608 (Cramer's V = .039). Demographic data for ethnicity of each student was not entered into the database;

Table 1. Demographics of participants.

	Pre-COVID ($n = 407$)		During COVID ($n = 110$)		Post-COVID ($n = 150$)	
Characteristic	*n*	%	*n*	%	*n*	%
Sex						
Female	244	60.0	67	60.9	86	57.3
Male	163	40.0	42	38.2	61	40.7
Other	0	0.0	1	0.9	3	2.0
AD/HD Diagnosis						
Yes	91	22.5	22	20.2	38	25.3
No	314	77.5	87	79.8	112	74.7
Mean Age	22.05 (17-56)		22.35 (17-48)		22.89 (17-52)	

Note. Mean age is reported in years, age range is in brackets; AD/HD: attention deficit/hyperactivity disorder.

however, a general review of all students referred to this center during that time period showed that the majority identified as White/Caucasian (72%), with the remainder identifying as Asian (12%), Black (6%), Middle Eastern (3%), and Other/not specified (7%).

Measures

The Conners' Adult AD/HD Rating Scales–Self-Report: Long Version (CAARS–S:L) (Conners et al., 1999) was administered to all participants as part of a more comprehensive assessment battery. The CAARS–S:L is a 66-item measure of self-reported adult AD/HD-related symptoms and behaviours, suitable for use with individuals 18 years of age and older. Test items are rated on a 4-point scale (0 = not at all/never, 1 = just a little/once in a while, 2 = pretty much/often, 3 = very much/very frequently). The resulting test indices include factor-derived subscales: inattention/memory problems; hyperactivity/restlessness; impulsivity/emotional lability; and problems with self-concept. Those who score high on inattention/memory problems may experience difficulties such as trouble concentrating, difficulty planning or completing tasks, forgetfulness, absent-mindedness, and being disorganized. High scores of hyperactivity/restlessness may materialize as problems with working on the same task for longer periods, feelings of restlessness, and fidgeting. The difficulties associated with impulsivity/emotional lability involve engaging in impulsive acts or decisions, having a low frustration tolerance, quick and frequent mood changes, and feeling easily angered and irritated by others. Difficulties with self-concept may include poor social relationships, low self-esteem, and low self-confidence. These four factors are weighted equally on the CAARS AD/HD Index, which is a measure of the overall level of AD/HD-related symptoms and is said to be "the best screen for identifying those "at risk" for AD/HD" (Conners et al., 1999, p. 23). These four factors have shown to be high in both internal consistency ($\alpha = 0.86–0.92$) and test-retest reliability ($\alpha = 0.80–0.91$) (Erhardt et al., 1999). The CAARS-S:L has three additional subscales that correspond with the DSM-IV diagnostic criteria for the respective subtypes—Inattentive Symptoms, Hyperactive-Impulsive Symptoms, and the DSM-IV AD/HD Symptoms Total scale that represents the sum of all the 18 listed DSM-IV symptoms, nine of which constitute self-reported inattention problems and nine representing hyperactive-impulsive symptoms as listed in DSM-IV (Conners et al., 1999). The CAARS-S:L was found to have an overall discriminant validity of 69% and had a high false positive and false negative rate in a post-secondary population (Harrison et al., 2019).

Procedure

Tests were administered and scored by trained psychologists and psychometrists and interpreted by licensed clinical psychologists. At the time of assessment, consent was obtained from all examinees for their anonymized test data to be used for future archival research, and consent for research was obtained from the university's Research and Ethics Board. All identifying information was removed before the data were employed for research purposes.

The diagnosis of AD/HD was made using a multi-method/multi-informant assessment protocol that included review of childhood report cards and medical records, obtaining retrospective information about childhood behaviours from parents/caregivers/relatives, exploration of current symptoms *via* clinical interview and by means of self- and collateral- reports, evaluation of current functional impairment *via* interview and clinical questionnaires, and ruling out of other possible causes for the currently-reported symptoms. This diagnostic protocol mirrors closely that recommended by Sibley (2021).

Results

An ANOVA analysis was conducted to determine whether there was a significant difference in T-scores on the CAARS-S:L indices. This analysis revealed significant differences in various AD/HD symptom scores across the three time periods: pre-COVID (January 2018–March 2020), during COVID (March 2020–September 2022), and post-COVID (September 2022–present 2024). Further testing was done to determine where the difference lay between the three groups using Tukey HSD multiple comparisons Post Hoc analysis.

As shown in Table 2, T-scores were shown to be significantly higher in the post-COVID group when compared to the pre-COVID group across the majority of indices (Inattention/Memory, Impulsivity/Emotional Liability, DSM Inattentive Symptoms, DSM Hyperactive-Impulsive Symptoms, DSM AD/HD Symptoms Total, and the AD/HD Index), while during COVID scores were not different from either group. Additionally,

Table 2. Mean *T*-scores for the subscales of the CAARS-S:L.

	Pre COVID ($n = 407$)		During COVID ($n = 110$)		Post COVID ($n = 150$)				
CAARS Scale	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	η^2
Inattention/ Memory	59.60^{b}	12.33	62.31^{ab}	11.64	63.05^{a}	13.77	5.06	.007	.015
Hyper/Restless	54.14	11.23	55.26	11.94	56.07	11.46	1.69	.185	.005
Impulsivity/ Emotional Lability	51.17^{b}	12.57	53.24^{ab}	12.51	55.84^{a}	13.42	7.51	<.001	.022
Problems with Self-Concept	56.95^{b}	11.67	60.05^{a}	12.14	60.71^{a}	11.49	7.10	<.001	.021
DSM: Inattentive Symptoms	67.31^{b}	14.26	70.80^{ab}	13.97	72.35^{a}	13.57	8.10	<.001	.024
DSM: Hyperactive-Impulsive	55.21^{b}	13.65	56.13^{ab}	14.13	59.69^{a}	14.52	5.70	.004	.017
DSM: AD/HD Symptoms Tot	63.56^{b}	14.85	66.19^{ab}	14.99	68.89^{a}	15.90	7.13	<.001	.021
AD/HD Index	57.55^{b}	12.04	60.29^{ab}	11.47	60.39^{a}	12.07	4.35	.013	.013

Note. Means with different superscripts are significantly different from one another based on Tukey HSD Post Hoc analysis; AD/HD = attention deficit/hyperactivity disorder.

T-scores from the Problems with Self-Concept index were significantly higher both during and post-COVID when compared to pre-COVID levels. There was no significant difference in T-scores across time periods on the Hyperactivity/Restlessness Index.

Discussion

This study aimed to investigate whether there has been an increase in self-reported AD/HD symptoms among clinic-referred post-secondary students since the onset of the COVID-19 pandemic. Our hypothesis, based on the findings of other researchers as well as our own clinical observations, was that rates increased during the pandemic and have not returned to pre-pandemic levels since that time.

The findings from our analyses indicate a significant increase in many AD/HD symptom domains both during and post-COVID-19 compared to pre-pandemic levels, supporting our hypothesis. Specifically, the results revealed statistically significant increases in scores related to inattention/memory, impulsivity/emotional lability, problems with self-concept, DSM-inattentive symptoms, DSM-hyperactive/impulsive symptoms, total AD/HD symptoms, and on the AD/HD index post-COVID when compared to the pre-COVID period. Only the problems with self-concept scores were significantly higher during the pandemic than before the pandemic, but all scores were trending in the direction of significance. These findings suggest that assessment seeking post-secondary students reported experiencing heightened difficulties in maintaining attention, managing impulses, regulating emotions, and maintaining a positive self-concept during and after the pandemic's onset. Further, results did not trend down following the resolution of the pandemic (rather they continued to increase), suggesting that it may not be the pandemic itself but rather associated factors that may be driving increased reporting of AD/HD symptoms in this population. At the same time, rates of clinical diagnoses of AD/HD did not change across time points, indicating that the increased symptom reporting was not due to changes in the diagnostic profile of the students presenting for assessment.

What could account for the increasing rates of reported AD/HD symptoms in our assessment-seeking sample from pre-COVID to after the COVID-pandemic? We can only speculate on the causes but have a few hypotheses to offer. The effects of the pandemic on student psychological well-being have been well documented, with several cross-sectional studies conducted at the height of the pandemic identifying high levels of anxiety, depression, and stress in post-secondary students (Husky et al., 2020; Son et al., 2020; Wang et al., 2020). Similarly, the longitudinal data from the NCHA survey shows that levels of self-reported distress and anxiety increased in post-secondary students across North America from 2019 to 2022, as did the number of students who reported being diagnosed with AD/HD (ACHA, 2024).

Research has long documented the impact of mental health conditions on cognition and behaviour (Castaneda et al., 2008; Gotlib & Joormann, 2010; Rayner et al., 2016). In fact, diagnostic criteria for many anxiety and mood disorders, as well as those related to exposure to acute or prolonged stressors, include "difficulty concentrating or mind going blank," "diminished ability to think or concentrate," "problems with concentration," "restlessness or feeling keyed up or on edge," and "psychomotor agitation" (APA, 2013). Even when not to the extent of clinical

diagnosis of a disorder, young adults without AD/HD diagnoses often report experiencing symptoms of AD/HD (Harrison, 2004; Suhr & Johnson, 2022; Weis & Waters, 2023) especially when they experience high levels of stress, depression, and/or anxiety (Harrison et al., 2013; Lewandowski et al., 2008; Suhr & Johnson, 2022). Thus, research supports that experiencing high levels of anxiety, depression, and/or stress can cause otherwise non-AD/HD people to experience AD/HD-like symptoms.

In addition to acute mental health effects of the pandemic onset and lockdowns, there is emerging evidence that the pandemic has had a persistent negative impact on youth mental health. Despite the lifting of pandemic restrictions, adolescents have continued to experience high levels of psychiatric symptoms at least two years after restrictions were lifted (Thorisdottir et al., 2023). As such, the increase in reported symptoms of AD/HD in our sample may be related to increased experiences of mental health symptomology reported in adolescent populations both during and post the pandemic.

Also possibly explaining the increase in reported symptoms is early and extensive exposure to digital media. Even before the pandemic, evidence was emerging that high frequency of digital media use appeared to play a role in the development of AD/HD symptoms in previously non-symptomatic adolescents (Ra et al., 2018). Use of digital media surged during lockdowns, and this has been linked to impaired cognitive, behavioural, and emotional development, potentially contributing to the onset or worsening of AD/HD symptoms (Mesce et al., 2022). A study conducted by Sriwaranun et al. (2023) concluded that increased recreational screen time (not for school or work) associated with the lockdowns was associated with worsening of AD/HD symptoms in children with AD/HD diagnoses. Additionally, the frequent use of technology and exposure to misinformation on social media apps such as TikTok may play a significant role in the increasing rates of adolescents and emerging adults presenting to practitioners with concerns regarding possible symptoms of AD/HD (Harrison & Pollock, 2025; Yeung et al., 2022).

Regardless of the cause of increased symptom reporting in assessment-seeking young adults, these findings have clinical implications for clinicians. According to the CAARS manual, T-scores above 65 on any of the subscales may indicate an area of clinically significant problems (Conners et al., 1999). The same manual states that scores between 66 and 70 are "much above average" and scores above 70 are "very much above average." Notably, in the present study the AD/HD symptom total score on the CAARS increased to the clinically significant level during COVID and remained in this range after lockdown ended. Additionally, experienced symptoms of inattention, consistent with DSM criteria, increased substantially both during and post-COVID, with scores moving from "much above average" to "very much above average." Thus, if the practitioner considered only self-reported symptoms, these findings could lead to inaccurate diagnoses of AD/HD.

Thus, our findings underscore the importance of ensuring that all five of the DSM-5 criteria for diagnosis of AD/HD are confirmed in young adult clients rather than merely relying on self-reported current symptoms alone. Indeed, recent studies show that the base rate of experienced AD/HD symptoms in non-AD/HD post-secondary students is high (Suhr & Johnson, 2022; Weis & Waters, 2023), especially in young women with preexisting anxiety or depression symptoms (Vizgaitis et al., 2023), meaning that inattention and/or hyperactivity symptoms are not unique to those with AD/HD. Sibley

et al. (2018) recommend that clinicians carefully scrutinize discrete environmental or biological antecedents in young adults presenting for a first-time evaluation of AD/HD, and ensure that all DSM criteria are met before making this diagnosis. Consistent with this advice, while reported experiences of AD/HD-like symptoms did increase during and after COVID, actual diagnoses of AD/HD (based on meeting all five DSM-5 criteria) did not. This supports previous research stating that young adults can experience heightened symptoms of AD/HD for other reasons, such as other common mental health disorders, unhealthy lifestyles, extremely taxing environments, or excessive use of electronics (Harrison & Edwards, 2023; Harrison & Pollock, 2025; Sibley et al., 2018; Vizgaitis et al., 2023). Given that the prevalence of severe mental health disorders has increased substantially in teens and young adults (Haidt, 2024), such other causes must therefore be examined and ruled out by clinicians before making a first-time diagnosis of AD/HD in individuals in this age range. Clinicians may also find it beneficial to discuss the amount of recreational screen time with the client to rule out the effects of digital media dependence and/or misinformation gleaned from social media (Harrison & Pollock, 2025; Mesce et al., 2022; Sriwaranun et al., 2023; Yeung et al., 2022).

Limitations and future research

This study has several limitations. First, it relies on self-reported symptoms, which may be subject to bias. Like many other self-report measures, the CAARS:S-L reflects a subjective impression of symptoms and behaviour rather than providing an objective report of the subject's behaviour (Marshall et al., 2021). Future research may wish to incorporate more objective measures of functioning and/or observer/informant reports of symptoms to further understand whether the student's subjective experience of symptoms is notable in behaviour. Moving forward, our plan is to also evaluate whether symptom report credibility has changed post-COVID, perhaps in line with increased misinformation about AD/HD symptoms being circulated online.

Second, the study focuses on assessment-seeking post-secondary students, which may limit the generalizability of the results to other populations. However, as this is the population often presenting to clinicians for assessment, we thought this was an important group to study. Additionally, the participants do not reflect a racial/ethnicity/culturally diverse population, with the majority being white university/college students. Further research should explore the impact of the pandemic on AD/HD symptom reports in different age and racial groups and settings.

Furthermore, while it can be hypothesized that increased mental health symptomology may explain increased reporting of AD/HD symptomology, this preliminary study did not empirically explore this hypothesis. While our results clearly show an increase in self-reported AD/HD symptoms in an assessment seeking post-secondary sample, the CAARS-S:L is a symptom-specific measure. As such, we cannot determine whether the observed increases are unique to AD/HD symptoms or reflect a broader rise in psychological symptom reporting during and after the pandemic. As such, future studies are encouraged to investigate the impact of mental health and/or other factors on reported AD/HD symptomology. Such research should also explore whether symptom overreporting in general might be increasing and whether this might help explain increases in the reporting of AD/HD symptomology. Future studies should

additionally include additional measures that assess non-AD/HD-specific symptoms (e.g., general distress, anxiety, depression) to determine whether the pattern of increased reporting is specific to attentional and impulsive symptoms or part of a more generalized trend in post-secondary populations. We are currently conducting a follow-up study examining this question directly but have chosen to report these results separately to preserve the clarity and focus of the present paper.

Finally, the current study essentially explores three different cohorts who were assessed at three different periods of time. As such, cohort effects may have impacted the results. Data from longitudinal studies may be helpful to confirm whether specific individuals experienced increased AD/HD symptomology over the same time periods.

Conclusion

In summary, this study provides insight into the potential impact of the COVID-19 pandemic on self-reported AD/HD symptoms amongst assessment-seeking post-secondary students, most of whom did not meet formal diagnostic criteria for AD/HD. Our findings suggest a notable increase in AD/HD symptoms during and post-pandemic, highlighting the importance of considering the broader social and environmental factors that may exacerbate AD/HD symptomatology in this population. To our knowledge, this is the first study to demonstrate such differences in self-reported AD/HD symptoms specifically within an assessment-seeking post-secondary student population. This underscores the need for further research and tailored support services to address the reported challenges experienced with inattention, impulsivity, emotional lability, and self-concept by post-secondary students in the post-pandemic era.

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