



Revista Latinoamericana de Psicología

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ORIGINAL

Relationships among behavioural and emotional symptoms, ADHD diagnosis, attentional complaints, and sex in young adults

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Received 12 November 2023; accepted 8 July 2024

Abstract | Introduction: Research has shown the importance of differentiating Attention Deficit Hyperactivity Disorder (ADHD) from subjective complaints of attention difficulties. In both cases, there is a clinical manifestation that differentially affects women and men. This study assessed the potential relationships among Behavioural and Emotional Symptoms, ADHD Diagnosis, Attentional Complaints, and Sex in Young Adults between 18 and 25 years of age. **Method:** Using a cross-sectional design, we examined the relationships across three groups (diagnosed with ADHD, attentional complaints, and controls) in a sample of 232 participants ($Mean_{age} = 20.38$ years, $SD_{age} = 1.81$ years; 52% women). We employed the Adult ADHD Self Report Scale and the Toulouse Pieron Test to classify participants among groups; for measures of behavioural/emotional symptoms using the Minnesota Multiphasic Personality Inventory-2 – Restructured Form (MMPI-2-RF), through High-Order and Somatic/Cognitive Scales. **Results:** Multivariate Analysis of Variance (MANOVA) revealed a significant relationship between group membership and the MMPI-2-RF variables after controlling for sex ($p < 0.01$). Post hoc tests indicated group differences across all variables except for Head Pain Complaints. Additionally, comparisons between men and women revealed significant differences in Behavioural and Emotional Dysfunction, and Gastro-Intestinal Complaints. **Conclusion:** The findings highlight the importance of making a diagnosis that is not only based on a list of symptoms and signs but also takes into account differences in sex, emotional/behavioural alterations, and associated connections to increased rumination in young adults, which may influence self-assessment bias and contribute to overestimation or underestimation of ADHD symptomatology.

Keywords: ADHD, behavioural/emotional symptoms, self-report, young adults.

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Relaciones entre los síntomas conductuales y emocionales, el diagnóstico de TDAH, las quejas atencionales y el sexo en adultos jóvenes

Resumen | Introducción: Las investigaciones han demostrado la importancia de diferenciar el trastorno por déficit de atención con hiperactividad (TDAH) de las quejas subjetivas de dificultades de atención. En ambos casos existe una ma-

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<https://doi.org/10.14349/rlp.2024.v56.14>
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nifestación clínica que afecta diferencialmente a mujeres y hombres. Este estudio evaluó las posibles relaciones entre los síntomas conductuales y emocionales, el diagnóstico de TDAH, las quejas atencionales y el sexo en adultos jóvenes de entre 18 y 25 años. **Método:** Utilizando un diseño transversal, examinamos las relaciones entre tres grupos (diagnosticados con TDAH, quejas atencionales y controles) en una muestra de 232 participantes ($Media_{edad} = 20.38$ años, $DE_{edad} = 1.81$ años; 52 % mujeres). Empleamos la escala de Autoinforme de TDAH en Adultos y la prueba Toulouse Pieron para clasificar a los participantes entre grupos; para medidas de síntomas conductuales/emocionales utilizamos el inventario multifásico de personalidad de Minnesota-2 – Forma reestructurada (MMPI-2-RF), por medio de las escalas de Alto Orden y las Somáticas/Cognitivas. **Resultados:** El análisis multivariado de varianza (Manova) mostró una relación significativa entre el grupo y las variables del MMPI-2-RF después de controlar el sexo ($p < 0.01$). Las pruebas post hoc indicaron diferencias entre grupos en todas las variables excepto en quejas de dolor de cabeza. Además, las comparaciones entre hombres y mujeres revelaron diferencias significativas en la disfunción conductual y emocional y en las quejas gastrointestinales. **Conclusión:** Los hallazgos resaltan la importancia de realizar un diagnóstico que no se base únicamente en una lista de síntomas y signos, sino que también tenga en cuenta las diferencias de sexo, las alteraciones emocionales/conductuales y las conexiones asociadas con una mayor rumiación en adultos jóvenes, lo cual puede influir en el sesgo de autoevaluación y contribuir a una sobreestimación o subestimación de la sintomatología del TDAH.

Palabras clave: TDAH, síntomas conductuales/emocionales, autorreporte, adultos jóvenes.

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Attention Deficit Hyperactivity Disorder (ADHD) is characterised by the presence of symptoms associated with inattention, impulsivity, and hyperactivity (Faraone & Larsson, 2019). This disorder has a heterogeneous etiology with persistent neurological development (Faraone et al., 2015; Nigg et al., 2020). Research suggests that approximately 2/3 of children diagnosed with ADHD will experience symptoms when they are older (Turgay et al., 2012). However, many individuals are not assessed for ADHD during childhood and continue to experience symptoms into adulthood without diagnosis (Rivas-Vazquez et al., 2023). Although generally conceived of as an early-onset disorder, social circumstances in adulthood may facilitate its expression (Franke et al., 2012).

The diagnosis of self-reported attentional deficits can be common among young adults, and although many meet the ADHD criteria, few seek help or are diagnosed (Cheng et al., 2014). These individuals often display deficits in attentional control (Hasler et al., 2016), mood changes (Hsu et al., 2019), and affective issues similar to those diagnosed with ADHD (Giupponi et al., 2020). The lack of formal clinical assessments in adults with ADHD significantly impairs social, academic, and occupational functioning (Rivas-Vazquez et al., 2023).

Currently, there is no consensus regarding sex-related variations in ADHD patients (Carucci et al., 2023). The prevalence of this disorder is generally greater in males than in females when the diagnosis is based on reports made by parents or primary caregivers of their children's behaviour (Quinn & Madhoo, 2014). However, this difference can be partly explained by the underdiagnosis of ADHD in women, as their symptoms may manifest differently and be less visible (Hinshaw et al., 2022; Millenet et al., 2018). Some studies have shown that females with ADHD may present more depression and anxiety problems (Nussbaum, 2012; Rucklidge, 2010; Young et al., 2020), and this sharing of symptoms with emotional disorders can lead to misdiagnosis (Quinn & Madhoo, 2014). Women are at greater risk of developing suicidal ideas (Biederman et al., 2008) and of planning

and executing suicide attempts (Encuesta Nacional de Salud Mental, 2015). Men, on the other hand, tend to show more aggression (Zimmermann et al., 2012) and other externalising behaviours, such as substance abuse (Kolla et al., 2016). While ADHD symptoms such as inattention, impulsivity, and hyperactivity occur in both males and females (Anbarasan et al., 2022), their nature and severity seem to differ.

Research suggests that people with ADHD not only are aware of their alterations, but also that the perception of these changes may be significantly influenced by the presence of emotional symptoms (Young et al., 2008). Anxiety, characterised by uncontrollable negative intrusive thoughts regarding specific future events or outcomes, is frequently associated with mental distress and physical discomfort (Hirsch & Mathews, 2012). Within this framework, excessive worry is strongly related to rumination, which is characterised by repetitive negative thoughts and an ineffective focus on its symptoms, causes, and consequences (Horton et al., 2024; Nolen-Hoeksema et al., 2008).

Negative self-assessments of cognition and attention are more associated to behavioural/emotional symptoms than to actual cognitive functioning (Fell et al., 2023; Hsu et al., 2019). They appear to be due to issues with critical functions of emotional regulation (Derryberry & Reed, 2002) that involve risky behaviours and rumination, which are caused by an inability to properly respond to the demands of the context (Charles, 2011). These problems lead to daily difficulties with learning and other functions (Pierre et al., 2019). Thus, it is important to study cognitive processes and behavioural/emotional symptoms that may be shared among people with ADHD and those who have not been diagnosed.

Some research has shown that individuals without ADHD may incorrectly perceive themselves as exhibiting symptoms of the disorder, leading to 'false positives', which are erroneous results indicating the presence of ADHD symptoms when there are none (Booksh et al., 2010). Therefore, diagnosis should not be based

only on meeting the subjective criterion of completing a symptom checklist (Jenkins et al., 1998), as is the case for most screenings (Faraone & Larsson, 2019; Quiroz-Padilla et al., 2022).

The behavioural and emotional dysfunctions of adults with ADHD are far-reaching. Studies have found that with more ADHD symptoms reported, individuals have higher levels of suicidal ideation (Balazs & Keresztesy, 2017), greater risk of internet addiction and susceptibility to psychiatric comorbidity (Cheng et al., 2014), problems with self-concept and self-efficacy (Newark et al., 2016), and lower quality of life and social support (Pinho et al., 2019). All these issues can significantly impact academic achievement (Martin et al., 2017), job performance (Rosario-Hernández et al., 2020), and executive functioning skills in general (Bueno et al., 2017). It is worth noting that there is a need for more research that differentiates the symptomatology mentioned above. Therefore, the current study aimed to assess the potential relationships among Behavioural and Emotional Symptoms, ADHD Diagnosis, Attentional Complaints, and Sex in Young Adults between 18 and 25 years of age. We hypothesised that there would be significant differences between groups in terms of behavioural/emotional symptoms and sex.

Method

Participants

A convenience sample of 232 Colombian young adults (18 to 25 years of age) was recruited via private psychiatric services and academic events ($Mean_{age} = 20.38$ years, $SD_{age} = 1.81$ years; 48% Male, 52% Female). All participants had to be enrolled in university programmes at least in the second semester. To confirm the diagnosis of ADHD in patients in terms of clinical-behavioural and cognitive performance symptoms (and to discard any suspicion of clinical ADHD in the control group), each participant was first enrolled in a screening session in which their results were reported in the *Adult Self-Report Scale (ASRS-v1.1)* and attentional performance tests (*Toulouse Pieron Test*). Based on the results of the screening session, the participants were assigned to one of three groups, namely, adults diagnosed with ADHD (ADHD group), adults presenting attentional complaints that did not meet the diagnostic criteria for ADHD, which is known as underdiagnosis (Complaint group), and adults presenting neither ADHD nor any attentional complaint (Control group).

Specifically, the inclusion criteria for the ADHD group were functional alterations in an attention-demanding task and symptoms identified by the ASRS. All participants in this group had a previous ADHD diagnosis given by a clinician. The Complaint group demonstrated adequate performance in the attention-demanding task but reported significant symptoms of ADHD (underdiagnosed ADHD). In contrast, the Control group did not exhibit symptoms according to any of the criteria but had demographic characteristics similar to those of the other two groups. The exclusion criteria were the presence of any congenital disease, cognitive deficit, brain damage, or personality disorder.

Measurement tools

Adult ADHD Self-Report Scale (ASRS-v1.1). The ASRS-v1.1 is a self-report questionnaire commonly used for adult ADHD diagnosis that comprises 18 questions, focusing either on attention (Part A) or impulsivity (Part B), that are answered using a 5-point Likert scale according to the frequency of certain behaviours in a person's life, ranging from *Never* to *Very frequently* (Barceló-Martínez et al., 2016). The ASRS demonstrated satisfactory validity and reliability (Cronbach's $\alpha = 0.92$) within the Spanish-speaking population (Gonzalez-Hernandez et al., 2023).

Toulouse-Pieron Revised Test (TP-R). The TP-R is a psychometric test that assesses perceptual and attentional capabilities, which requires great focus and resistance to fatigue (Toulouse & Piéron, 2013). The task consists of 1600 figures spread across 40 lines, and the participant has 10 minutes to go through the figures line by line, marking each time they find one of two figures shown at the top of the page. The test showed adequate indicators of validity and reliability (Cronbach's $\alpha = 0.95$) in the Spanish-speaking population (Toulouse & Piéron, 2013).

Minnesota Multiphasic Personality Inventory-2 Restructured Form (MMPI-2-RF). The MMPI-2-RF is a standardised psychometric test that evaluates adult personality and psychopathology. It includes 338 questions with true or false answers (Ben-Porath & Tellegen, 2008). The test has multiple subscales: for this study, the *Higher-Order* (Emotional Dysfunction, Thought Dysfunction, and Behavioural Dysfunction) and *Somatic/Cognitive Complaints* (Neurological, Gastro-Intestinal, Cognitive, and Head Pain complaints) subscales were used. The test demonstrated satisfactory validity and reliability (Cronbach's α males = 0.91, females = 0.90) within the Spanish-speaking population (Ben-Porath & Tellegen, 2008).

Procedure

The data were collected over two sessions, each lasting approximately one hour, with one week between each session. Participants in the ADHD group were contacted through various health services and universities, while those in the Complaint and Control groups were recruited using only the latter method. Those who voluntarily agreed to participate in the research were scheduled for the first assessment session. In this session, participants signed informed consent, and socio-demographic, clinical, and medical data were collected via open-ended questions, in addition to the neuropsychiatric assessment comprising the ASRS and the Toulouse-Pieron test. In the second session, behavioural/emotional symptoms were evaluated using the MMPI-2-RF. Expert evaluators conducted both assessments. The assessments for all three groups were conducted simultaneously, and the participants did not receive any form of compensation. After the evaluation, participants received only a neuropsychological feedback report. All items were completed on the scales, indicating no missing data. An automated system was implement-

ed to ensure the comprehensive collection and organisation of the data obtained during the two sessions.

Statistical analysis

The statistical analyses included Multivariate Analysis of Variance (MANOVA) to assess the impact of group membership (Control, Complaint, or ADHD), with sex (Male or Female) as a covariate, on the Somatic/Cognitive Complaints and High-Order scales. The assumptions of MANOVA, such as the homogeneity of covariance matrices, linearity, and multivariate normality, were assessed, and the results for each demonstrated appropriateness for conducting the test. The dependent variables comprised scores from various MMPI-2-RF subscales, including Emotional Dysfunction, Thought Dysfunction, Behavioural Dysfunction, Neurological Complaints, Gastro-Intestinal Complaints, Cognitive Complaints, and Head Pain Complaints. Bonferroni-adjusted post hoc tests were used to examine differences in dependent variables according to group membership, and independent-sample *t* tests were used to compare sex differences. All analyses were performed using SPSS® version 23.

Results

The final sample comprised 232 participants between 18 and 25 years of age ($Mean_{age} = 20.38$ years, $SD_{age} = 1.81$ years; 48% Male, 52% Female). See Table 1 for the composition of the different groups and Supplementary Table 1 for complete descriptive results. The MANOVA showed a significant effect of group division with sex as a covariate (see Table 2) in the measures of Somatic/Cognitive Complaints and the High-order subscale of the MMPI-2-RF. After applying Bonferroni correction for multiple comparisons, significant differences were observed among all variables except for Head Pain Complaints (See Table 3).

Table 1. Group composition

Independent variables	Group		
	Control	Complaint	ADHD
Sex			
Male (<i>n</i>)	44	39	28
Female (<i>n</i>)	40	44	37
Subtotal (<i>n</i>)	84	83	65
Total (<i>n</i>)	232		

Note. ADHD = Attention Deficit Hyperactivity Disorder group.

Finally, the independent-sample *t* tests revealed significant sex differences. Behavioural Dysfunction was higher for men ($t = 4.24, p < 0.001$), while Gastro-Intestinal Complaints ($t = 4.69, p < 0.001$) and Emotional Dysfunction ($t = 1.03, p < 0.001$) were higher for women. However, Head Pain Complaints ($t = 4.45, p = 0.305$), Thought Dysfunction ($t = 1.35, p = 0.179$), Neurological Complaints ($t = 1.40, p = 0.162$), and Cognitive Complaints ($t = 0.14, p = 0.888$) did not reach statistical significance. These results are illustrated in Figure 1.

Discussion

This study aimed to investigate the relationships among Behavioural and Emotional Symptoms, ADHD Diagnosis, Attentional Complaints, and Sex in Young Adults between 18 and 25 years of age. This approach has gained importance in recent years due to the need to understand psychopathology beyond the mere presence of signs and symptoms, allowing for a better diagnosis of an individual's dysfunction level (Insel et al., 2010).

The subjective complaints group showed increased deficits in behaviour, emotions, and thoughts, as well as more pronounced neurological, cognitive, and gastrointestinal issues, compared to the control group. This data proposes that the former presents higher dysfunction in high-order scales and somatic/cognitive alterations than the ADHD group, possibly due to a greater negative self-assessment of their symptomatology relating to attentional problems, an aspect that may be due more to behavioural/emotional symptoms than to actual cognitive deficits (Hsu et al., 2019). These findings align with studies indicating a link between ADHD and increased worry and rumination as possible underlying symptoms in young adults (Fredrick et al., 2020; Yeguez et al., 2018). A high prevalence of this cognitive pattern has been particularly observed in university students reporting inattention (Jonkman et al., 2017). Negative thoughts often result in inappropriate reactions and negative self-evaluations. Thus, a person's own self-assessment bias and negative ruminating patterns of thought could cause them to either overestimate or underestimate their symptomatology (Fuermaier et al., 2015). This could be related to the high rate of false positives (overdiagnosis and underdiagnosis) found in research and diagnostic protocols that rely on self-reports of ADHD, which, as a subjective measure, is very easy to misinterpret or respond to dishonestly (Booksh et al., 2010). Hence, these observations offer a potential rationale for why individuals

Table 2. Multivariate Analysis of Variance

	Pillai's Trace			Wilks' Lambda			Hotelling's Trace			Roy's Largest Root		
	Value	F	Sig.	Value	F	Sig.	Value	F	Sig.	Value	F	Sig.
Intercept	0,54	36,71	< 0,01	0,46	36,71	< 0,01	1,16	36,71	< 0,01	1,16	36,71	< 0,01
Sex	0,24	10,14	< 0,01	0,76	10,14	< 0,01	0,32	10,14	< 0,01	0,32	10,14	< 0,01
Group	0,26	4,82	< 0,01	0,75	4,96	< 0,01	0,32	5,10	< 0,01	0,27	8,61	< 0,01

Note. Value = Estimated effect of the group on the dependent variable; F = The F value, represents the ratio of the variability between groups to the variability within groups; Sig = Indicates the level of statistical significance associated with the F value.

Table 3. Post hoc multiple comparison for MMPI measurements by group

Dependent Variable	Mean difference	Standard Error	Significance	95% Confidence Interval	
				Lower	Upper
High-Order Scales					
Emotional dysfunction					
Control-Complaint	-4,37	1,25	< 0,01	-7,39	-1,35
Control-ADHD	-2,74	1,34	0,12	-5,96	0,48
Complaint-ADHD	1,63	1,34	0,68	-1,60	4,86
Thought Dysfunction					
Control-Complaint	-1,42	0,49	0,01	-2,60	-0,23
Control-ADHD	-0,97	0,52	0,20	-2,23	0,30
Complaint-ADHD	0,45	0,53	0,87	-0,82	1,72
Behavioural Dysfunction					
Control-Complaint	-1,74	0,52	< 0,01	-2,99	-0,50
Control-ADHD	-1,56	0,55	0,02	-2,89	-0,23
Complaint-ADHD	0,19	0,55	0,84	-1,15	1,52
Somatic/Cognitive Complaints					
Neurological Complaints					
Control-Complaint	-1,59	0,33	< 0,01	-2,38	-0,79
Control-ADHD	-0,60	0,35	0,28	-1,45	0,26
Complaint-ADHD	0,99	0,35	0,02	0,14	1,85
Gastro-Intestinal Complaints					
Control-Complaint	-0,51	0,18	0,02	-0,95	-0,08
Control-ADHD	-0,38	0,19	0,15	-0,85	0,08
Complaint-ADHD	0,13	0,19	0,82	-0,34	0,60
Cognitive Complaints					
Control-Complaint	-2,35	0,37	< 0,01	-3,24	-1,46
Control-ADHD	-1,10	0,39	0,02	-2,05	-0,15
Complaint-ADHD	1,25	0,40	< 0,01	0,30	2,20
Head Pain Complaints					
Control-Complaint	-0,25	0,25	0,99	-0,86	0,36
Control-ADHD	0,31	0,27	0,74	-0,34	0,97
Complaint-ADHD	0,56	0,27	0,12	-0,09	1,22

Note. ADHD = Attention Deficit Hyperactivity Disorder group.

who present attentional complaints manifest a greater frequency of neurological and cognitive symptoms than both control and ADHD patients. In that sense, rumination and worry responses may be associated not only with neurological complaints but also with other physical and cognitive symptoms (Brinker et al., 2014).

The etiology and symptomatology of ADHD are very heterogeneous, which partially explains why it has been challenging to understand the mechanisms that cause its associated deficits (Drechsler et al., 2020). Most people with ADHD report various problems with be-

havioural and cognitive functioning, especially aspects related to executive functions such as self-monitoring, self-awareness, and self-regulation (Butzbach et al., 2021). Additionally, research has linked attentional control to the active perception a person has of their behaviour and performance (Fernie et al., 2016), a process that is often negatively affected in people with ADHD (Salmi et al., 2018; Whitney et al., 2017). This evidence corroborates the findings of the research, showing differences in cognitive processes and behavioural dysfunction between the ADHD and control groups.

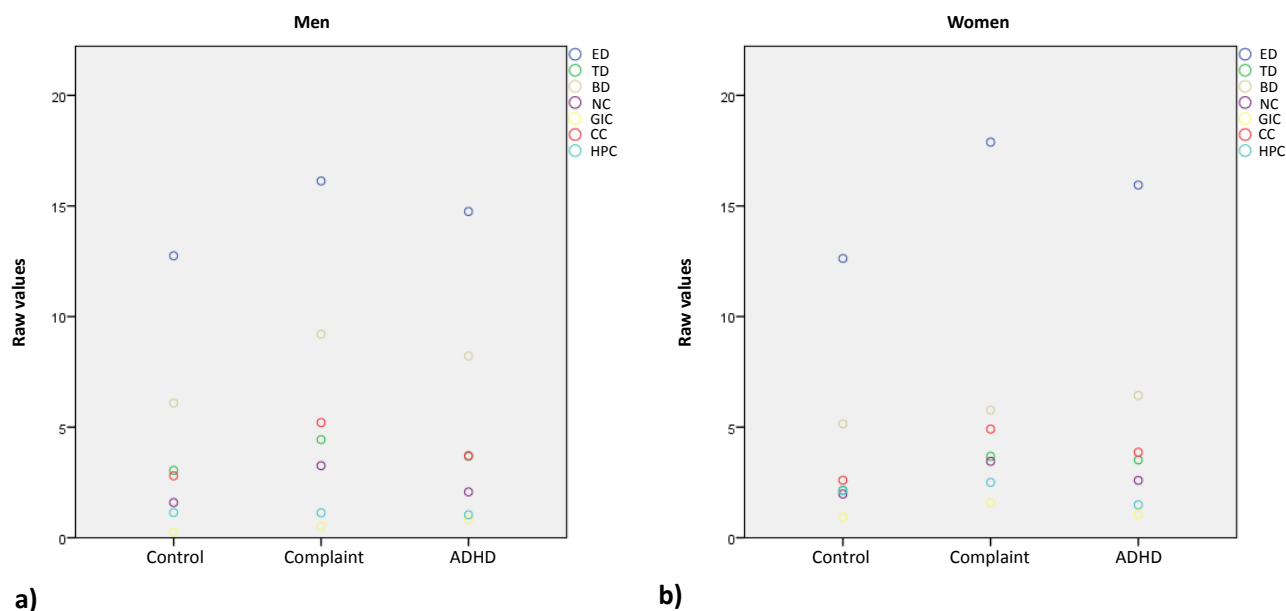


Figure 1. Sex differences between groups. The y-axis labelled 'Raw values' represents the direct scores of each of the MMPI-2-RF subscales. ADHD = Attention Deficit Hyperactivity Disorder group. The graph shows the mean in each group for the following scales: ED = Emotional Dysfunction, TD = Thought Dysfunction, BD = Behavioural Dysfunction, NC = Neurological Complaints, GIC = Gastro-Intestinal Complaints, CC = Cognitive Complaints, HPC = Head Pain Complaints

Our data also suggest that men display more behavioural dysfunction, while women present more complaints of gastrointestinal and emotional problems. These findings are consistent with many genetic (Faraone et al., 2021; Pavlov et al., 2012), neurofunctional (Cross et al., 2011), and endocrine (Doi et al., 2015) studies that have identified more aggressive and externalised behaviours in men (Jauregui et al., 2023; Kolla et al., 2016; Zimmermann et al., 2012) and in women showing more symptoms of emotional disorders (Álamo et al., 2020; Mayes et al., 2020; Young et al., 2020).

The differing symptomatology in women has historically been confused and even treated in different ways, on many occasions, without being clear about what might be explaining it. According to some authors, one of the complications of later diagnosis of psychological disorders in women is that they are more likely than men to exhibit anxiety, depression, sensory overload, and eating disorders (Álamo et al., 2020; Chronis-Tuscano, 2022). Although females and males may experience the same symptoms with ADHD, these can be expressed in different ways between the two sexes (Millenet et al., 2018). Females with childhood ADHD self-report increased levels of ADHD symptoms upon reaching adulthood (Millenet et al., 2018). This same group often faces greater difficulties in relationships with parents and peers, and they tend to have lower self-esteem than males with ADHD. These challenges persist into adulthood, where women typically have a more negative self-perception than men with this diagnosis (Quinn & Madhoo, 2014; Rucklidge & Kaplan, 1997). Different studies have shown that boys diagnosed with ADHD display elevated levels of hyperactive behaviours and encoun-

ter greater difficulties in inhibition and cognitive flexibility than girls diagnosed with the disorder (Loyer Carbonneau et al., 2021). Despite the commonly described hyperactivity reduction in adults, given the developmental stage of the current sample (primarily emerging adults), it is possible that such symptoms could still be significant (Lin & Gau, 2019; Young et al., 2020). This might explain the behavioural problems in males.

To conclude, our findings suggest the importance of making a diagnosis that is not based only on a list of symptoms and signs but also takes into account differences in sex, emotional/behavioural alterations, and associated connections to increased rumination in young adults, which may influence self-assessment bias and contribute to overestimation or underestimation of ADHD symptomatology. All of the above factors should be considered in the improved design of diagnostic and treatment protocols that allow differentiation based on functional alterations, complemented by the evaluation of clinical/behavioural symptoms.

Future studies should consider evaluating a broader age range to encompass a wider spectrum of developmental stages and age-related variations in ADHD symptomatology. Additionally, improving the sampling process, which was nonprobabilistic in this study, would enhance the generalisability of the findings. Subsequent iterations could benefit from larger sample sizes with matched groups, enhancing the robustness of the conclusions. Finally, additional cognitive measures could support a finer-grained differentiation between performance profiles in patients with and without ADHD, improving our overall knowledge of this disorder.

Declarations

Funding: This work was funded by the *Universidad de La Sabana* under grants PSI-68-2019 and MED-329-2022; and by the *Ministerio de Ciencia, Tecnología e Innovación de Colombia* under grant 807-2018, 123080762966.

Competing interests: The authors have no relevant financial or non-financial interests to disclose.

Ethics approval: The present research received approval from the institutional Ethics Committee of the Universidad de La Sabana (approval 67-05/04/2018) and was conducted in accordance with the latest version of the Declaration of Helsinki, the code of conduct of the American Psychological Association (1992), and the laws of the country where the study was carried out.

Consent to participate: Informed consent was obtained from all individual participants included in the study.

Acknowledgments

The authors would like to thank the following units of the Universidad de La Sabana: Laboratorio de Bases Biológicas del Comportamiento – Facultad de Psicología y Ciencias del Comportamiento, and Doctorado en Biociencias – Facultad de Ingeniería. Also to the Instituto Nacional de Medicina Genómica de México - INMEGEN.

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Supplementary materials

Supplementary Table 1. Descriptive statistics by sex and group

Sex	Group	Emotional Dysfunction		Thought Dysfunction		Behavioral Dysfunction		Neurological Complaints		Gastro-Intestinal Complaints		Cognitive Complaints		Head Pain Complaints	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Men	Control	12.750	8.196	3.045	2.505	6.091	3.333	1.591	1.703	0.250	0.615	2.795	2.018	1.136	1.488
	Subjective Complaint	16.128	8.095	4.436	3.719	9.205	3.496	3.256	1.888	0.513	0.942	5.205	2.525	1.128	1.508
	ADHD	14.750	8.588	3.679	3.400	8.214	4.272	2.071	1.585	0.821	1.219	3.714	2.507	1.036	1.290
Women	Control	12.625	7.712	2.150	1.994	5.150	2.704	1.975	2.348	0.925	1.228	2.600	1.945	2.125	1.800
	Subjective Complaint	17.886	7.530	3.682	3.388	5.773	3.041	3.455	2.387	1.591	1.530	4.909	2.550	2.500	1.947
	ADHD	15.946	8.586	3.514	3.805	6.432	3.346	2.595	2.598	1.054	1.268	3.865	2.740	1.486	1.609

All data correspond to raw values. SD = Standard Deviation.