Diagnosing and Treating Women with AD/HD

by Kathleen Nadeau, Ph.D.

AD/HD is one of the most highly researched childhood psychiatric conditions, however, less than one percent of that research has focused on the issues of girls, and even less research has addressed women with AD/HD. We do not yet have good statistics about the numbers of girls or women with AD/HD, but current evidence suggests that girls have been seriously under-diagnosed. Joseph Biederman, M.D., the leader of a major AD/HD research group at Massachusetts General Hospital in Boston, considers the under-diagnosis of females to be a serious public health concern.

Diagnosis

A major barrier in the diagnosis of women with AD/HD is that the current diagnostic criteria were developed to describe young boys with hyperactive/impulsive patterns. Gender-appropriate diagnostic criteria are badly needed. A self-report questionnaire for women with AD/HD, the Self-assessment Symptom Inventory (SASI) has recently been developed to help address this problem, however, research to validate the SASI and to develop norms remains to be done. Self-report questionnaires for both women and girls can be found at www.addvance.com. (At present, these questionnaires should be used as structured interviews, and cannot be considered diagnostic tools.)

Few mental health professionals in practice today have received training in the diagnosis of adults with AD/HD, and even fewer in the diagnosis of women. As a result, when a woman seeks diagnosis and treatment, she faces a difficult challenge to find a professional who is aware of the different ways that AD/HD may present in females. Women may struggle with significant AD/HD issues, but remain undiagnosed because they don't meet the current diagnostic criteria. Several common barriers to diagnosis are:

The requirement that age of onset is prior to age seven. The majority of females fall into the "predominantly inattentive" type of AD/HD. Recent studies have confirmed what many clinicians have observed—that many of those with primarily inattentive AD/HD do not manifest symptoms that are noted in early childhood. In addition, there is some evidence that many girls do not manifest symptoms until puberty, when fluctuating female hormones intensify AD/HD symptoms.

The requirement that impairment in two or more settings be documented in childhood. Academic impairment in the classroom—the pattern that most clinicians look for—may not be evident in the elementary school years. Girls tend to work harder for teacher approval, and work harder to hide their attentional difficulties. Girls with mediocre academic performance may be dismissed as "average" with no consideration of possible AD/HD. Furthermore, girls are much less likely to be oppositional, defiant, or have behavior problems in the classroom that would result in referral for treatment.

Females are less likely to be hyperactive/impulsive, and the behavior of those who are, may look very different than males. Most teachers are trained to look for hyperactivity and impulsivity in children with AD/HD. Most girls with AD/HD don't show

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signs of hyperactivity. And the patterns of hyperactivity in girls may look very different than those of boys. They may be hyper-talkative, hyper-social, or hyper-reactive emotionally.

Mental health professionals are more familiar with conditions that commonly co-exist with AD/HD and are prone to focus on these while overlooking AD/HD. Females with AD/HD are more likely to struggle with co-existing anxiety and depression. Clinicians familiar with these diagnoses are more likely to recognize and treat the anxiety and depression, while overlooking the co-existing and possibly primary AD/HD.

Protective factors may delay the onset of AD/HD symptoms. Girls with AD/HD who do not have co-existing conditions such as learning disabilities, who have a high IQ, and who have supportive family and school environments may not manifest AD/HD symptoms until much later. Women with a history of average or above average academic achievement during school years may find that their AD/HD concerns are dismissed because they don't fit the expected patterns.

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Treatment

Many women with AD/HD never receive an appropriate diagnosis. Women who are diagnosed with AD/HD face the challenge of receiving appropriate treatment.

Physician reluctance to prescribe stimulants to adult women. Some clinicians are inexperienced in treating adults with AD/HD and are uncomfortable prescribing stimulant medication to adults. Although stimulants have been well established as the first-line medication for treating AD/HD, many physicians opt for a second-line treatment such as an antidepressant, which may be less effective.

Hormonal issues in medical treatment. Recent research has explored the important role that estrogen plays in the cognitive functioning of women. It is well known that some women experience significant problems with moodiness and depression during low estrogen states such as the premenstrual period each month, the postpartum period following birth, in perimenopause and menopause. We're now beginning to recognize that low estrogen states also have a strong impact on cognitive functioning that can increase AD/HD symptoms in females.

When an adult with AD/HD reports that stimulant medication has become less effective, the most common physician response is to increase the stimulant dose. This approach may not be appropriate or effective, however, if the problem has resulted from declining estrogen. Very few physicians recognize this estrogen connection and take it into consideration in planning treatment.

Co-existing Conditions

Appropriate, effective treatment becomes even more challenging when co-existing conditions complicate the diagnostic and treatment picture. Often, in those cases in which a woman has received prior treatment for a co-existing condition, her AD/HD has never been identified and treated. Studies show that treatment success is much greater when the AD/HD is diagnosed and appropriately treated along with co-existing conditions.

Typically, because the recognition of AD/HD in women is still very recent, clinicians are not experienced in combination treatments for AD/HD and co-existing conditions. Clinicians may mistake hyperactive/impulsive behavior patterns in women for bipolar symptoms. In women who have both bipolar disorder and AD/HD, clinicians may fear that stimulant medication for AD/HD may trigger a manic episode, and are reluctant to prescribe stimulants. Others may not be aware that stimulants may not be tolerated and effective in women with significant anxiety, unless the anxiety is well controlled with medication.

Common co-existing conditions in women include:

- Depression
- Anxiety
- Bipolar disorder
- Sleep disorders
- Eating disorders
- Addictions

Psychological Treatment

Aside from medication treatment issues, women with AD/HD face different challenges that need to be addressed in therapies specifically designed for them.

The challenges of motherhood. Most parenting programs, including those for children with AD/HD, begin with an assumption that the mother does *not* have AD/HD and will be able to implement and maintain systems for her child with AD/HD. New parenting programs need to be developed that help the mother and child take charge of AD/HD issues in the home.

Self-esteem issues. Recent research suggests that women, more than men, struggle with low self-esteem as a result of their AD/HD. Therapy designed for women needs to directly address this issue—helping women to reframe their view of AD/HD, helping them to stop blaming and criticizing themselves, and helping them to develop a more positive self-image.

Social skills and interpersonal relationships. Research suggests that even as early as preschool, females with AD/HD experience social rejection or social neglect that impacts them very negatively, contributing to their low self-esteem. Treatment programs for females—girls as well as women—should focus on their need to address their social skill deficits, as well as actively create a more accepting social environment in their work and personal lives.

The challenges of daily life. While many men with AD/HD build support systems around them—administrative assistants, business partners, wives—who can assist them in daily life tasks and organization, women traditionally are expected to *be* the support system for others. At work, they are less likely to be in a position to have an administrative assistant, and more likely to be in a job that requires *them* to perform administrative tasks. At home, most women still play the role of primary parent and homemaker.

Treatment of women needs to focus on:

- Becoming more realistic in their expectations of themselves
- Creating more AD/HD-friendly home environments
- Developing and maintaining organizational strategies
- Utilizing time-management techniques to meet multiple daily demands
- Giving themselves permission to seek the support they need

Where Do We Go from Here?

We are at the beginning of a very exciting journey. Growing recognition of the unique issues of girls and women by CHADD and other advocacy organizations is an important first step in gaining the knowledge that we need to accurately identify and appropriately treat women with AD/HD.

AD/HD research needs to focus more on the needs of girls and women—developing more appropriate diagnostic criteria and exploring treatment approaches that may be more effective for females.

Clinician training is desperately needed on gender issues related to AD/HD. Few clinicians are familiar with the unique issues of women. For now, women must serve as their own best advocates, working to develop awareness, and working to educate the professionals in their community about the diagnostic and treatment issues of women with AD/HD. ■

Kathleen G. Nadeau, Ph.D, is co-editor, with Patricia Quinn, M.D., of two recently published books on women's AD/HD issues, *Understanding Women with AD/HD,* and *Gender Issues and AD/HD.* Dr. Nadeau is also the co-author of *Understanding Girls with AD/HD* a book on the AD/HD issues of girls. She also co-founded the National Center for Gender Issues and AD/HD (NCGI), a non-profit advocacy organization for girls and women with AD/HD (www.ncgiadd.org).

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