Females with ADHD: Different or not so different?

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Presentation objectives

- How to ‘spot’ ADHD in female patients, in adolescence and early adulthood
- What ‘red flags’ should you look out for in this patient group?
- How to assess ‘signs and symptoms’ that are often missed
- The issues and challenges that teenage girls and young women face
- ‘Top Tips’ on how you might improve and enhance positive outcomes in females with ADHD

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RESEARCH ARTICLE Open Access

Females with ADHD: An expert consensus statement taking a lifespan approach providing guidance for the identification and treatment of attention-deficit/hyperactivity disorder in girls and women

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Abstract

Background: There is evidence to suggest that the broad discrepancy in the ratio of males to females with diagnosed ADHD is due, at least in part, to lack of recognition and/or referral bias in females. Studies suggest that females with ADHD present with differences in their profile of symptoms, comorbidity and associated functioning compared with males. This consensus aims to provide a better understanding of females with ADHD in order to improve recognition and referral. Comprehensive assessment and appropriate treatment is hoped to enhance longer-term clinical outcomes and patient wellbeing for females with ADHD.

Methods: The United Kingdom ADHD Partnership hosted a meeting of experts to discuss symptom presentation, triggers for referral, assessment, treatment and multi-agency liaison for females with ADHD across the lifespan.

Results: A consensus was reached offering practical guidance to support medical and mental health practitioners working with females with ADHD. The potential challenges of working with this patient group were identified, as well as specific barriers that may hinder recognition. These included symptomatic differences, gender biases, comorbidities and the compensatory strategies that may mask or overshadow underlying symptoms of ADHD. Furthermore, we determined the broader needs of these patients and considered how multi-agency liaison may provide the support to meet them.

(Continued on next page)

Newham follow up 8-15 years

Young et al. 2005, Eur Child Adolesc Psychiatry; 2005, J Child Psych Psychiatry.

CONSENSUS STATEMENT (2020):
Females with ADHD: guidance for identification and treatment

- November 2018 - invited multidisciplinary experts in the field, service-user and charity representations
- Presentations
- Breakout 3 groups – core topics to discuss guided by a facilitator
  - How presentation differs to males and triggers for referral
  - Assessment
  - Pharmacological and non-pharmacological
  - Educational and other multi-agency considerations
- Facilitators present consensus for whole group agreement
- Entire day is recorded – write up supported by medical writer

UKAP
THE UK ADHD PARTNERSHIP
Building better futures for children with ADHD

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How to spot ADHD in females: Symptoms

- Symptoms are similar to males but may be lower in severity, especially hyperactivity/impulsivity

- Greater and more severe comorbidity – including severe mental illness, in-patient psychiatric admissions, emotional lability, irritability, low frustration tolerance, anxiety, depression, alcohol and cannabis use, borderline personality disorder, eating disorders, chronic fatigue syndrome, fibromyalgia, body dysmorphic disorder

- *Some evidence*: hormones may exacerbate ADHD symptoms during menstrual cycle, pregnancy, peri/postpartum periods and menopause

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How to spot ADHD in females: Behaviour

- *Behaviour*: Presentation differs to the perception that ADHD is a 'behavioural disorder' characterized by boisterousness, aggression, oppositional and conduct problems. Female conduct is more impulsive and emotionally driven

- *Crime*: Females are generally less likely to come into contact with the criminal justice system, yet meta-analysis of international prison data found no significant difference in ratio of males/females in prison (26%)

- *Accidents/risk*: Mortality rate (MR) of people with ADHD is nearly six times higher than general population - driven by accidental deaths. Female MR is over double that of males

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Have you ever impulsively lashed out?

"I've smashed four windows. I've smashed the front door window two times. I've run away six times when I was with a bloke, me ex".

"Fights…yeah, slapping teachers. The teachers get on my nerves so I'll just slap them or tell them what I think of them. One teacher kept me in detention and I picked up a chair and threw it at her".

"I've carried a knife, bottles, a gun…not a gun-gun but a pellet gun…I smashed a bottle once to show I weren't f…..g around and they backed off"

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How to spot ADHD in Females: Academic and Occupational Functioning

- Similar to males with ADHD
- Education: later completion, repeating years, re-takes, suspension, exclusion, lower attainment, drop out, specific learning difficulties, truancy
- Inattention is highly predictive of academic underachievement
- High turnover of jobs, type of work, lower productivity

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How do you get on at school?

"I thought I was going to fail, and we haven't got our exam results yet either and I've still got this doubt that I haven't got anywhere and that I've probably failed and that I haven't worked hard enough"

"I thought I was going mad…doing everything wrong. I just couldn't concentrate on things. I never had enough confidence to do things. I don't know why"

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How to Spot ADHD in Females: Social Functioning

- High turnover of friendships, peer rejection, social isolation.
- Experience more bullying than non-ADHD peers (physical, social-relational, cyber-bullying). ADHD boys more likely to be aggressors or victims of physical aggression.
- Problems amplified by applying a range of ineffective and/or dysfunctional strategies to resolve peer relationship problems.
- Some seek a social network by forming damaging relationships (join a gang, promiscuity, compliance/used by others for crime).

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Tell me about your friends

“I make friends OK, but I can’t keep them…I’ve always been a loner. I just don’t get on with people…so I decided not to have any friends. If you don’t have no friends you can’t get hurt by them”

“When I spend time with them, it’s like I have to try and a talk about what they are talking about. Well I was told that my brain is younger than what I am, you know, like I talk about things they don’t want to know…so I don’t mix with them lot ‘cos its hard for me to talk about things with them”

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How to Spot ADHD in Females: Psychosexual

- Females with ADHD become sexually active earlier, have more sexual partners and engage in unsafe sexual practices.
- Sexually transmitted infections, unplanned or early pregnancies are elevated in girls and women with ADHD.
- Harsh, lax or negative parenting styles have been identified to be elevated in mothers with ADHD.

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Red Flags - watch out for patterns that may include:

- Academic problems, specific learning problems, feeling ‘overwhelmed’
- Disparity between educational performance and achievement
- Anxiety, depression, emotional volatility and dysregulation
- Deliberate self-harm, picking, cutting, suicidal ideation/attempts
- Interpersonal relationship problems, conflict, impulsive ‘lashing out’
- Presentation at sexual health services, early sexual behaviours
- Sensation seeking and risk-taking (via social networks, internet use)
- Elevation of ADHD symptoms at times of transition (personal, educational, health)
- Inadequate/dysfunctional coping strategies (alcohol, cannabis)
- ‘Buffering’ and camouflaging behaviours

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Assessment – Rating Scales

- Rating scales are not diagnostic instruments but tools to aid diagnosis and monitor clinical progress.

- If used to screen, scores falling just below cut offs should not exclude referral and/or a comprehensive clinical diagnostic assessment.

- Norms often based predominantly on male samples, which may disadvantage use in females. Some provide normative data for females:
  - Conners' Comprehensive Behavior Rating Scales
  - Strengths and Difficulties Questionnaire
  - Nadeau and Quinn Inventories

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Clinical Assessment

- Semi-structured clinical interviews helpful - symptom presentation may change over time for both males and females.

- Make small modifications to capture female-centric behaviour (e.g. ‘excessive talking and giggling’ instead of ‘excessive talking’).

- Collateral information from independent sources may be less reliable if source perceives ADHD is a ‘behavioural disorder’. School reports often omit social engagement and behaviour.

- Objective assessments are not specific markers of ADHD and should only be used to augment the clinical decision-making process.
  - ➢ QB scales have normative data specific to each sex.

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Clinical Assessment

- Assess for age-appropriate common co-occurring conditions for females with ADHD – look out for the ‘red flags’.

- Consider factors that might make symptoms worse (e.g. stress) or better (e.g. strategies).

- Teenage/adult females may apply dysfunctional strategies (alcohol, cannabis, DSH) to manage emotional turmoil, social isolation and rejection.

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Clinical Assessment

- Symptoms may be minimized, masked and/or ‘camouflaged’ by accommodations at home/school/occupation. Watch out for bravado, masking, buffering (“I’m fine”, “ok” - may lead to an underestimation of underlying problems).

- Compensatory strategies may be successfully applied for a brief period of time to cope with specific situations (but can’t be sustained).

- DSH is common, impulse driven and sometimes ‘hidden’

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How do you see yourself?

“I’m the sort of person who thinks negative all the time”

“They’ll put me down saying ‘oh, you’re stupid, you silly girl”…whatever...and I am.

I do things silly to prove them right...and I’ll do it again...just to make them see I’m stupid. If they want to believe it then I’ll show it...that’s what I do. If I’m stupid then I’ll act stupid and I’ll be stupid”.

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Clinical Risk Assessment

- Assess risk:
  - Social attitudes and behaviours
  - Quality of relationships
  - Coping strategies
  - DSH/ideation
  - Eating habits
  - Alcohol/drug use
  - Internet use
  - Unsafe sexual practices
  - Victimisation and potential for exploitation
  - Violence (emotional lability)

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Have you ever been violent or carried a weapon?

"All my arguments end up in fights"

"They start…I finish. I tend to strangle but most of the time I just punch"

"A year ago I used a knife on someone cos he stuck a pencil in me. It was only a little pen-knife...only a little scratch on his hand. I always carried a flick knife on me"

"I called it [bread knife] 'Baby'…my 'Baby' it was…I only used it for protection"

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Pharmacological Treatment

- Recommendations don't differ by sex and only modestly by age.

- Improve engagement/adherence with psychoeducation (to girls and p/c) about available treatments, what they target, side effects, *possible* impact of hormonal changes (during puberty, the menstrual cycle and menopause) on the effectiveness of stimulants.

- Treatment response may be better captured through individualised targets to assess outcomes (rather than rating scales)
  e.g. measuring emotional regulation and academic attainment.

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Pharmacological Treatment

- Ask females to track/diarise their symptoms to establish patterns. Adjust doses if required during periods of hormonal change.
- Consider interactions between ADHD medications and treatments for comorbidity.
- Explore medication titration around menstrual cycle if this is a presenting problem. (NB. Minimal evidence and anecdotal support for interaction with hormones)

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Pharmacological Treatment

- If mood symptoms are apparent but not pervasive, treat the ADHD symptoms first and monitor for improvement prior to considering or initiating antidepressant treatment (may be due to demoralization driven by ADHD).

- Discuss risks of alcohol/drug use whilst on ADHD medications.

- If eating disorders are a concern, be mindful of appetite suppression if stimulants are prescribed.

- Be aware that symptoms may overlap with those indicating an emergent personality disorder (e.g. borderline).

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What do you do when you are upset or worried?

"I was eating and making meself sick to lose weight…some days I won't eat nothing at all apart from me tea or apart from me breakfast and I'll feel dizzy an' that the next day and a bit weak"

"If I have something worrying me, I don't know, it controls me and I stop eating for about a week"

"Sometimes I just get depressed for no apparent reason...I'll do nothing, won't talk to anyone, won't see anyone, nothing...but other times I'm like happy and jumping about. I just get depressed, it comes on like that, I don't know why, but it does"

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Pharmacological Treatment - Motherhood

- Prescribing ADHD medication during pregnancy or breastfeeding is not advised.
- Mothers with ADHD may experience difficulties in managing their own symptoms alongside the increased demands from family life.
- Difficulties may be augmented if their children have ADHD.
- More frequent reviews of dosage/monitoring of treatment response.
- Consider needs and how these may be met with ancillary support.

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Psychological Interventions

- CBT, coaching and psychoeducation with content tailored to meet needs. Regular reviews at times of key transitions (personal, health).

- For children, group and individual sessions working directly with the child may be helpful additions to p/c mediated treatments.

- Individual treatments may be more appropriate for those with severe symptoms, intellectual limitations and/or can't tolerate group sessions.

- Long-term complex, entrenched problems – schema focused therapy (psychological mind mapping)

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Have you ever self-harmed?

"There were times when I would have a knife and I would really want to use it…I scratched myself all down my chest once. There was another time when I burnt myself with boiling water."

"I just got upset and I just started to slice my arms and I must have done it about 150 times."

"I used to hurt myself, I cut my arms…That's why I get in trouble a lot cos I aint got no one to talk to and it builds up and I end up being naughty. But I don't tell nobody. I just don't trust anyone."

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Psychoeducation and COPING strategies (age dependant):

- Be prepared! Challenges they will face at home, school/occupation, interpersonal, social and how to respond.
- *Possible* worsening of symptoms at times of hormonal change.
- Social-relational difficulties/motivations, peer pressure, critical feedback, rejection, social isolation, stigma, bullying/victimization.
- Multi-tasking, meeting deadlines/demands/expectations, parenting.
- Reduce dysfunctional coping strategies (DSH, picking, cutting, suicidal ideation, substance use especially alcohol, cannabis).

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Have you ever thought about committing suicide?

"Once a month when something upsets me and its really bad"

"Yeah…things were like getting on top of me…schoolwork and family things, stuff like that. Things got too much to cope with, I just got really low"

"It was in the first two years in school an' that. I felt like my whole world had crumbled with my mum and friends not talking to me.

Plus, I used to always be late for school and the teachers used to be always on my back and everything, and so it was about that time I wanted to get rid of myself"

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They may impulsively act on the ideation

“I just sort of thought life wasn’t worth living and one day I took the paracetamol out of the cupboard and swallowed them all… I had to stay in hospital for three days. It was a spur of the moment feeling. I just took the tablets.
I didn’t write a note or nothing”

“Things weren’t going well with Mark [boyfriend]. I didn’t think about it. I just done it [tablets], just thought ‘might as well’.
I just bottle it up. I don’t cry. I bottle everything up inside”

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Psychoeducation and SKILLS development (age dependent):

- Cognitive/executive dysfunction: sustaining attention, organisation, time management, planning/prioritising/organising tasks
- Impulse control, emotional control and management, self-regulation (emotional lability, frustration, anger, anxiety, mood, DSH)
- Social skills training, setting/managing social boundaries, ‘rules’ of friendship, managing conflict, assertiveness training, negotiation steps
- Critical evaluation and problem-solving, decision making, consequential thinking, making choices

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Issues and Challenges

- Sex differences in rates of referral and diagnosis may be explained, in part, by perceived differences in symptom profiles
- Boys are referred for hard-to-manage behavioural problems – 'boisterous boys'
- Females are self-referring to primary care services in young adulthood but may be seen earlier for (severe) comorbid conditions/problems. ADHD is missed.
- We need to identify females when they are younger – they are not on the radar until mid/late adolescence when social/academic demands increase, level of support diminishes and serious clinical/social problems arise.

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Myths and Realities

MALES

~~Combined type~~

~~Externalising problems~~

Combined type

Internalising problems

Poor self-regulation

Emotional lability

Social problems

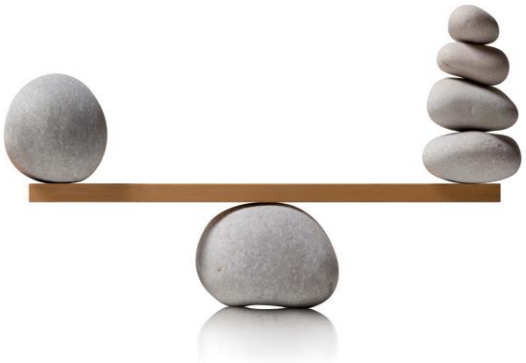
Risk-taking

Sensation-seeking

Behavioural problems

Disruptive/conduct

Aggression



FEMALES

~~Inattentive type~~

~~Internalising problems~~

Combined type

Internalising problems

Poor self-regulation

Emotional lability

Social problems

Risk-taking

Sensation seeking

Behavioural problems

Social-relational

Psychosexual

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Top Tips to support females: clinical

- Don’t just consider ADHD symptom presentation: include emotional lability, mental health, substance use, eating patterns, social-relational and psychosexual problems

- Forewarned is forearmed! Signpost parents/carers about elevated risk of specific problems that may later present (as they’ll increasingly receive direct interventions without input of parents/carers as they mature)

- Assess risk of deliberate self harm, eating disorders, SUD, psychosexual issues – specify in care plan (including triggers and maintenance factors)

- Assess needs and engage other agencies, if necessary – educational, social services, sexual health clinics, criminal justice system, drug and alcohol

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Top Tips to support females: psychosocial

- Psychosexual: sexual health and planning, sexual harassment, exploitation, abusive and/or inappropriate relationships

- Support with pregnancy, parenting - mothers with ADHD may be particularly vulnerable, especially if young, isolated and/or if the child has ADHD - consider needs and how these may be met with ancillary support

- Risk taking: social networks/gangs, sensation-seeking, promiscuity, unsafe sexual behaviours, sexting/posting inappropriate content, internet 'friends' and grooming

- Review at periods of personal transition (transition is not a solely a services exercise)

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Top Tips to support females: educational and occupational

- School liaison: raise awareness – mentors, academic and pastoral support, promote attendance and engagement to avoid early school leaving, special arrangements for exams, drug contracts etc.

- Further education support and careers advice: adjustments, accessing disabilities services, GP, support/mentoring

- Support with ‘access to work’, occupational psychology input

- Written information listing local support services – where to go and how to access help

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The Final Word…

- We need to change perceptions because ADHD in females is often missed or misdiagnosed.

- HCP's need to be mindful of 'red flags' - adjust your assessment to capture 'female-centric' difficulties, impairments and risks.

- Implications for treatment: Life is an uphill struggle - they are trying to 'find themselves', they want to be accepted and 'fit in'. They camouflage and cover up with 'bravado'. They need life skills and support to develop critical reasoning skills, functional problem-solving skills and coping strategies.

- Don't let them be 'leaves in the wind'.

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Do you think about the future?

"Yeah, every Sunday in the horoscopes"

"I wish I'd done better at school and...if I go to college and I don't get nothing out of it, that's probably the time...I can see myself trying to kill myself then. I dunno about the future, I think about it sometimes but not much"

"The only future I think about is like next week. I take each day as it comes. You plan something and it goes completely up the pole, so what's the point in planning?"

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Available in Afrikaans to download from the resources section of

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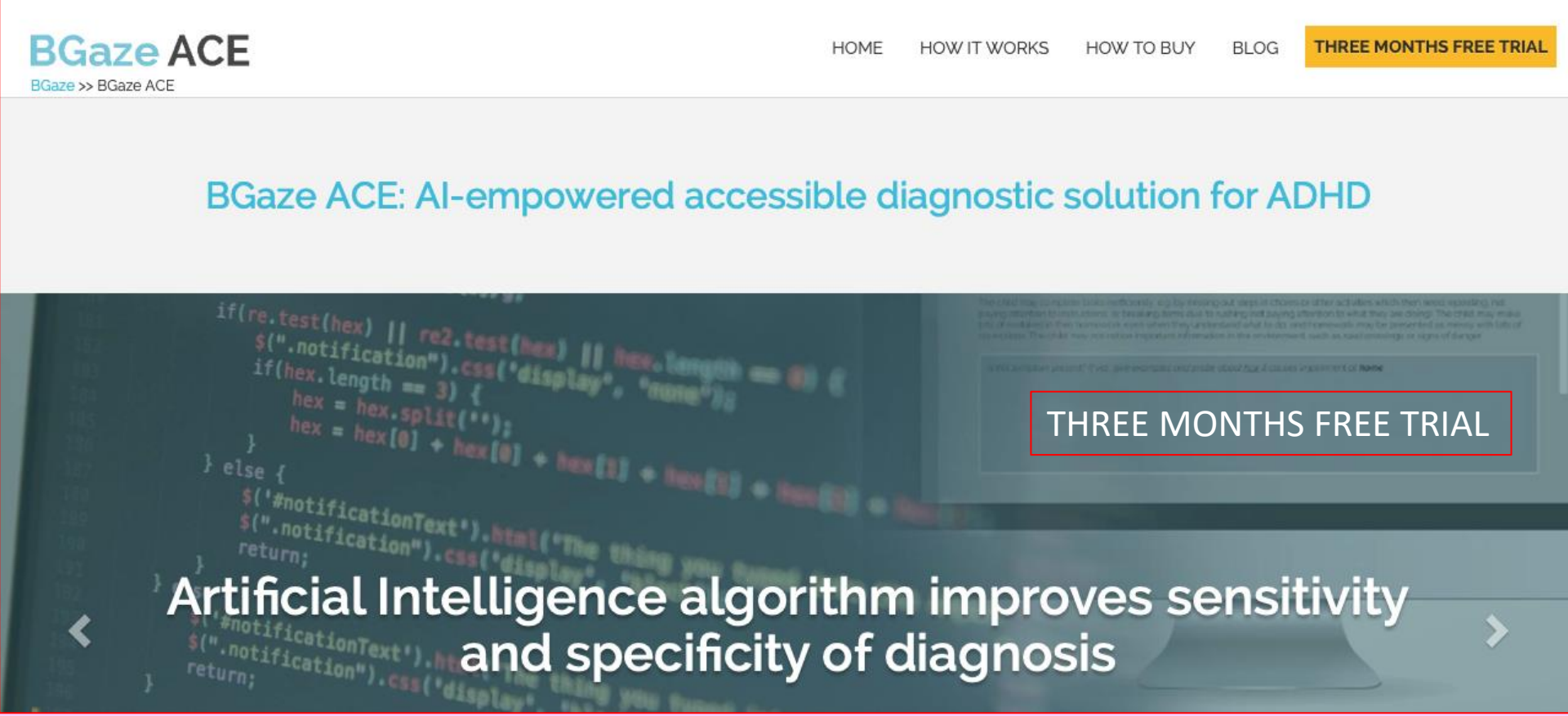

https://bgaze.com/en/ace

English, Spanish

Pre-assessment tools also available – for completion by self and informant

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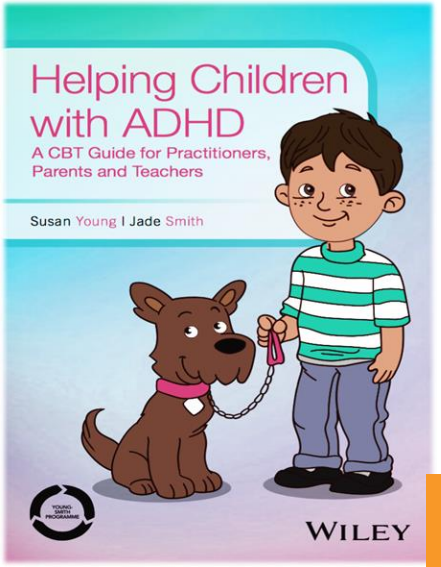
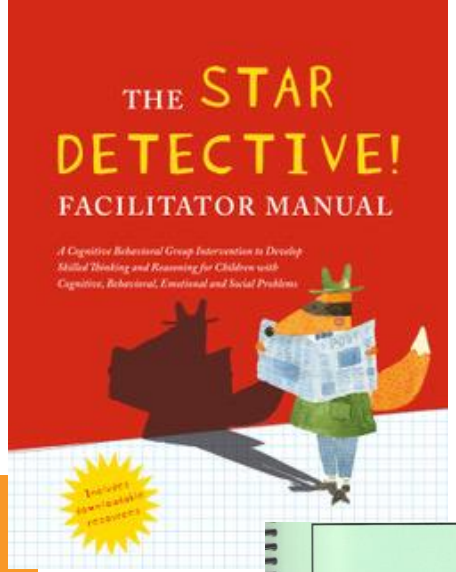
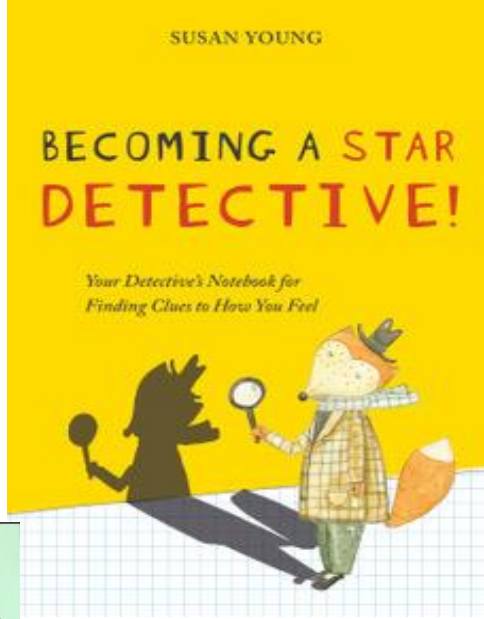
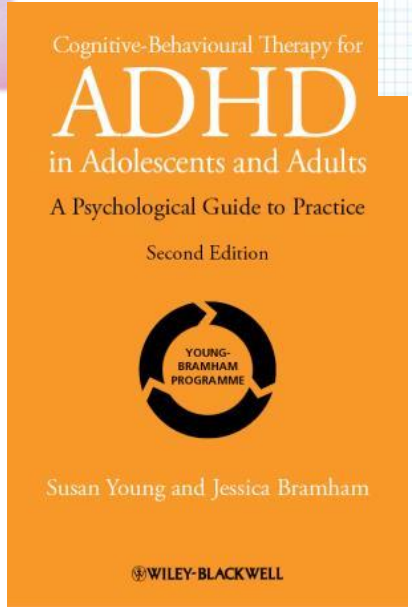
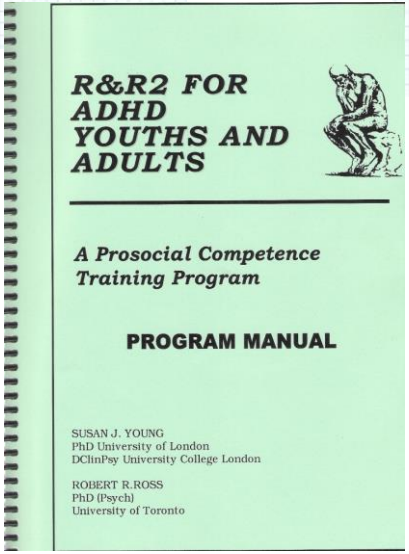

Helping Children with ADHD
A CBT Guide for Practitioners, Parents and Teachers
Susan Young I Jade Smith
WILEY


THE STAR DETECTIVE!
FACILITATOR MANUAL
A Cognitive Behavioral Group Intervention to Develop Skilled Thinking and Reasoning for Children with Cognitive, Behavioral, Emotional and Social Problems


SUSAN YOUNG
BECOMING A STAR DETECTIVE!
Your Detective's Notebook for Finding Clues to How You Feel


Cognitive-Behavioural Therapy for
ADHD
in Adolescents and Adults
A Psychological Guide to Practice
Second Edition
YOUNG-BRAMHAM PROGRAMME
Susan Young and Jessica Bramham
WILEY-BLACKWELL


R&R2 FOR ADHD YOUTHS AND ADULTS
A Prosocial Competence Training Program
PROGRAM MANUAL
SUSAN J. YOUNG
PhD University of London
DClinPsy University College London
ROBERT R. ROSS
PhD (Psych)
University of Toronto

OTHER CONSENSUS STATEMENTS

providing guidance about assessment, treatment and multi-agency liaison (in BMC Psychiatry open access)

- ADHD and Occupational Issues (Adamou *et al*., 2013)
- ADHD and Transition between services (Young *et al*., 2016)
- ADHD and Fetal Alcohol Spectrum Syndrome (Young *et al*., 2016)
- ADHD and the Criminal Justice System (Young *et al*., 2018)
- ADHD and Autism Spectrum Disorder (Young *et al*., in submission)

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Thanks to consensus co-authors:

Nicoletta Adamo, Bryndís Björk Ásgeirsdóttir, Polly Branney, Michelle Beckett, Bill Colley, Sally Cubbin, Quinton Deeley, Emad Farrag, Gisli Gudjonsson, Peter Hill, Jack Hollingdale, Ozge Kilic, Tony Lloyd, Peter Mason, Eleni Palikosta, Sri Perecherla, Jane Sedgwick, Caroline Skirow, Kevin Tierney, Kobus van Rensburg, Emma Woodhouse

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