Diagnosing and Treating Girls and Women with ADHD

Dr ShabeerJeeva - Specialist Psychiatrist - Melrose Arch, Johannesburg - www.adhdclinicjeeva.com

ADHD is one of the most highly researched childhood psychiatric conditions and since the 1970's it has been accepted as a disorder that is common throughout the life cycle. But less than 1% of that research has focused on the issues of girls and women.

Presentation of ADHD in male to female is 8:1 in childhood and 1:1 in adulthood. This change in gender ratio with age, suggests that gender appropriate diagnostic criteria is badly needed (Lahey 1994) (Weiss 2001). This is because the diagnostic criterion was developed to describe young boys with hyperactive/impulsive patterns and requires the age of onset is prior to age 7, with impairment in 2 or more settings.

Girls' manifest symptoms differently from boys, and many do not show symptoms until puberty, when fluctuating female hormones intensify ADHD symptoms (Nadeau, Quinn 2002); they are less likely to have disruptive behavioural problems in the classroom that could result in referral for treatment (Biederman 1994).

Girls' can be any of the 3 main types of ADHD – hyperactive/impulsive, inattentive and the combined type. In hyperactive girls there is less movement; they are talkative, social butterflies, show-offs, over emotional.

The ADHD "predominantly inattentive" type is more common in women, therefore many symptoms are not noted in early childhood (Ratey 1995) (Solden 1995). Classroom problems are not always evident during primary school, as these girls work harder for teacher approval. They look like daydreamers that are not living up to their potential and are dismissed as "lazy" or "average" without considering the possibility of ADHD. Their symptoms are less disruptive, like chronic underachievement, forgetfulness, inattention, disorganisation, loosing things, being easily distracted or trouble finishing tasks. Girls, who do not have coexisting conditions such as learning disabilities, have a high IQ, a supportive family and school environment may not manifest ADHD symptoms until later.

Teenage girls with untreated ADHD are more susceptible to family conflicts, peer pressure, social problems, repeating grades, alcohol abuse, smoking, low self-esteem, depression and anxiety disorders.

50% of women with ADHD experience comorbid levels of depression, anxiety, stress, external locus of control and lower self-esteem (Rucklidge et al. 1997) (Purgay et al. 2006). Fibromyalgia, sleep and eating disorders are also common. Many physicians tend to focus on this while overlooking the coexisting and possibly primary ADHD. Treatment for depression does not lessen the ADHD symptoms of disorganisation and overwhelm. In women with significant anxiety, stimulants may not be tolerated or effective, unless the anxiety is well controlled with medication.

Sometimes hyperactive/impulsive behaviour patterns are mistaken for bipolar symptoms. 15% of ADHD women are bipolar, and 25% of bipolar women have comorbid ADHD, making treatment more challenging. Physicians are reluctant to prescribe stimulants for ADHD, fearing it could trigger a manic episode, but it may be necessary and could be done under close supervision, with great results.

Few physicians recognise the estrogen connection and take it into consideration in planning treatment. Research shows that estrogen can function like a neurotransmitter, inserting itself directly into the cell during menopause. Some women experience significant problems with moodiness and depression during the premenstrual period, the postpartum period, peri-menopause and menopause because of low estrogen. Low estrogen affects cognitive

functioning and can increase ADHD symptoms during the menstrual cycle and more dramatically during menopause.

Research suggests that as early as pre-school, girls with ADHD experience social rejection or neglect that impacts them negatively, contributing to their low self-esteem.

The initial treatment for girls should be holistic and also focused on helping women reframe their view of ADHD, to stop blaming and criticizing themselves, creating a more accepting environment in their personal lives and work. Stimulants such as Ritalin and Concerta and non-stimulants, such as Strattera should be used routinely. Physicians tend to opt for second-line treatment such as anti-depressants, and a special note should be made that the SSRI's (Cipralex, Cirpramil, Prozac, Zoloft) are serotonin blocking drugs and not as effective as the tri-cyclic antidepressants (Imipramine) which works on noradrenaline and serotonin. The best choice of anti-depressant would be Welbutrin (bupropion) which works exactly where the stimulants work on dopamine and noradrenaline.

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Written by Tanya Sibilant – Research & Development – ADHD CLINIC

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