ONE

What Does ADHD Look Like in Girls?

Let's start with a basic question that comes up all the time: Is ADHD—the acronym for *attention-deficit/hyperactivity disorder*—truly experienced by girls? I'm tempted to make this a much shorter chapter by limiting my answer to a single word: YES!

But as you might expect, there's a lot more to discuss.

Plus, you might need some convincing if you've heard the myth that ADHD does not occur in girls or women.

Many of you may be beginning to worry, regarding your daughter, about some of the issues and problems listed below:

- Messiness and disorganization
- Her seeming to be "out of it" for overly long periods of time
- Lack of forethought, then facing consequences after the fact, the hard way
- Excessive forgetfulness
- The appearance of not listening
- Getting unmotivated when the material to learn gets really tedious or hard
- Lack of restraint—"I have to do it *now*!"
- Defiance
- Overemotional nature
- Overtalking or excessive fidgeting
- Way too many "grudge matches" at home

- Generally poor self-control
- Just can't seem to get or stay organized

If this is the case, you may well be wondering: Is she just not trying? Or is she attempting to wear you down and get her own way for reasons that you can't quite understand? Why are you spending so much time talking with her teacher(s), or your friends and neighbors, wondering what on earth might be wrong? You may feel, as do many parents in similar situations, that at times you can relate to your daughter—yet at other moments you can't quite quell the suspicion that her schoolwork and friendships, along with your family's daily interactions, are slowly going down the drain.

Or maybe not so slowly.

Overall, for parents who deal with ADHD in their offspring, there's often a great deal of frustration—paired with self-blame ("What did I do during her early years to have caused all this?" or "Why can't I just say the right thing to her, ever?!"). In fact, soon enough I'll be asking you to work extremely hard on altering your expectations for a daughter with ADHD, involving a *radical acceptance* of her differences from other girls (sometimes subtle, sometimes quite overt) paired with a *radical commitment* to changing the family climate, altering many of your parenting strategies, and working in conjunction with her teachers, other school personnel, clinicians, and supports in the community.

What do I mean by the term *radical* here? It's taken from the language of a treatment called *dialectical behavior therapy* (DBT), which is a form of psychotherapy for individuals with severe emotion dysregulation and, often, self-injurious behaviors. *Radical* acceptance in DBT means that the person fully accepts her (or his) current reality—of difficult life events, or of longstanding personality traits—while letting go of the bitterness surrounding them. Such acceptance of life difficulties (working not to let them act as a continued source of stress and agony) can paradoxically help individuals do what they can to problem-solve in productive ways (hence, *radical* commitment to enacting change strategies). Without such shifts, the road ahead will be long and full of unexpected curves, too often accompanied by high "doses" of anger and self-recrimination.

With radical acceptance and commitment, challenges will still clearly await you, but thriving becomes a distinct possibility. I discuss these concepts later on in the book as well.

Does ADHD Really Occur in Girls?

What's the truth about ADHD? I'll be the first to admit: Things can be really hard to sort out in light of the torrent of conflicting information about ADHD circulating in the traditional media and social media, where polar-opposite views abound:

- ADHD is a myth—a made-up condition allowing pharmaceutical companies to promote the drugging of innocent children.
- ADHD is a biological label for kids who are exposed to lax parenting and unresponsive schools. If we just changed the way society is run, ADHD would not exist.
- ADHD emerges exclusively from the genes one was born with—and medications are the only valid treatment. In other words, parenting and schooling don't really matter because a girl's underlying genetics and biology are all that count.
- Forget Western medicine—herbal and alternative treatments are the only way to go for girls with what people consider to be the medical diagnosis of ADHD.
- Girls don't "have" ADHD—it's other conditions and diagnoses that are at play when a girl is showing poor self-control.
- ADHD should be diagnosed in girls just as much as in boys, after decades of professional neglect of female manifestations of the condition.

And this is only a tiny sample. A real challenge is how to sort myth from reality based on the extreme statements and viewpoints that seem to come out of the woodwork.

In fact, along with a large number of scientists and clinicians, I firmly believe that ADHD is a reality, although a complex one. It encompasses a range of genetic, biological, family- and school-related, and cultural forces that come together to yield real impairments in perhaps 4% of girls, worldwide. In fact, the diagnosis is a real possibility if the girl in question has longstanding and troublesome issues with self-regulation, good judgment, and self-motivation, particularly when these issues negatively affect her performance at home, at school, and with peers—or, at least, would do so without an incredible amount

of outside support that might be keeping her barely afloat. At the same time, ADHD is not a diagnosis to be granted or received lightly. A host of other conditions can look a lot like it—and some may well accompany ADHD in a particular girl. Families need to take real care to obtain the best diagnostic work-up possible, as described in Chapter 2.

ADHD is real—and complex.

Still, when ADHD does exist in girls, the consequences can be monumental across a variety of important life areas, unless responsive support and intervention are put into action. The stakes are high.

This chapter will help you start to build an understanding of whether your daughter might have ADHD and what you should do about it if she does (and even if she doesn't). It's frustrating for all of us that longstanding misconceptions—to the effect that ADHD is only a "male" condition—have led to a real shortage of information on girls with ADHD until quite recently. If ADHD does exist in girls, how often does it occur compared to in boys? Do the symptoms look the same or quite different? For far too long, many in the research, clinical, and educational fields have believed that ADHD is utterly rare, if not absent, in girls. At the same time, misunderstandings abound as to the different ways that ADHD can present itself in girls' cognitive abilities, behaviors, and emotions.

Rather than gently trickling from a lawn sprinkler, information about ADHD gushes from a fire hose these days. As such, it could take an entire book (actually, an entire series of books) to sort fact from fiction, reality from myth. At the end of this book I provide a Resources appendix that includes recommended materials for further reading and further action. For now, I attempt to present as clear and cogent an overview as I can, to put into context the experience and reality of youth, particularly girls, experiencing ADHD.

To begin with, let's pause to ask how we, as a society, consider children who have a *really* hard time with the demands of schooling. That is, children who don't seem to adapt well to requests to sit for long periods of time or acquire skills for which the human mind clearly wasn't evolved to attain, such as learning to read or do formal math. Expectations for acquiring these difficult cognitive skills have been present for only the past several thousand years of our species. In other words, we've been asking young children to do things that were never required in the 100,000-plus years of humankind before now. If you have an inborn difficulty with such functions, little wonder—in our achievement-oriented world these days—that there would be conflict, strife, and developmental problems.

I'm referring to kids whose parents bemoan them as "challenges," showing problems that surpass those of their siblings or other youth in the neighborhood or school, in terms of both frequency and intensity. Included are children and adolescents who seem to be slow to mature, which is particularly noticeable as societies demand, at ever-earlier ages, high levels of focus, achievement orientation, and the ability to go for long periods of time without significant rewards. Pressures to succeed academically and vocationally have never been stronger, so woe to the child who appears not to fit the mold—especially girls, whom most of us perceive as "naturally" more obedient and school-focused than boys.

Finally, an important note: Much of the material in this book is written as though there's a firm line between male/female or boy/girl. But as we are all increasingly realizing, it's not necessarily a binary division. In fact, as emphasized in an important post by Holly Miles and Christelle Thibault for the organization Inclusive Therapists—*www.inclusivetherapists.com/blog/the-intersection-of-adhd-and-gender-diversity*—all too little is known about the presence and experience of ADHD or other neurodevelopmental disorders in youth (or adults) who are "two-spirit, transgender, non-binary, gender-fluid, genderqueer, or agender." In fact, this is an area in great need of research. Overall, as you read further please realize that we all need to learn a lot more about ADHD in relation to gender diversity.

In short, as our expectations of how children need to develop have evolved, so have our views of problems like ADHD—which can erect obstacles to meeting those expectations. But the stereotypes of such youth pertain almost exclusively to boys. Let's explore this exclusion in some detail.

A Brief History of ADHD: Where Are the Girls?

Before the invention of the alphabet and written language, children with strong tendencies toward inattention, impulsivity, or hyperactivity may not have been recognized unless their problems were ultrasevere in the home or in the fields where they often worked alongside adults. Over the past several thousand years, only the children of royalty or the very wealthy were expected to learn to read and write. Yet even in preliterate, preagricultural societies, children displaying extreme problems with inattention or impulsive behavior might have been handicapped. Think of a preteen or teen in a hunter-gatherer society.

Some amount of risk taking and exploration may have led to discovery of the tribe's next meal. But an overly careless, rushed, and thoughtless style, involving a lack of attention and planning on the "hunt," may have led to misfires with a rock, spear, or bow and arrow, leaving the tribe desperately hungry.

Still, it's no coincidence that depictions of what is now termed ADHD began to emerge in the medical and educational communities when compulsory education became prevalent, in the early 1800s and beyond. Any child whose negative behavior (in a mandatory classroom) was disruptive might well threaten the learning of all classmates. (Think of the one-room schoolhouses in rural areas, or more factory-like classrooms in urban districts, where behavioral control was at a premium.) Extremes of distractibility, poor impulse control, and the inability to sit still for long periods at a time would stand out like a sore thumb.

But girls unable to meet these expectations have been a perpetual mystery. Boys were typically expected to be mischievous and unruly, but a girl showing these tendencies was believed to be far outside the norm. Even more, girls with difficulties in self-regulation were (and still are) less likely than boys to show truly disruptive, obstreperous, or oppositional behavior. Instead, their more frequent problems with inattention, disorganization, and careless mistakes were (and still are) not as bothersome to adults. To this day, teachers may actually be relieved that such girls can at least follow basic classroom rules for deportment. Fortunately, the last three decades have seen recognition of ADHD in girls finally come of age. But even now, the core view in medicine, psychology, and education remains in place that girls with core issues in compliance, attention, and self-control must have something far different from ADHD at the root of their problems.

Girls with the hallmark symptoms of ADHD are still often thought to have some other problem.

It Was All about (Mis)Behavior . . .

How did we get here? Let's look back at how ADHD was conceptualized early in its history. When compulsory schooling began to take hold, the medical profession struggled to account for children who had at least average intellectual abilities, experienced no vision or hearing loss, and were able to recognize reality (that is, not be overtly psychotic)—but nonetheless showed major difficulties

with self-regulation, rule following, and the ability to sustain attention and resist distraction. Just after the turn of the 20th century, a notable account specifically described these kinds of children (noted to be predominantly boys) as having a "defect in moral control." This description did not mean that such children were inherently "immoral" but instead that they had major issues with regulating their behavior in accordance with social and adult norms. Unfortunately, the connotation of such children as "bad" or immoral has not entirely left our views, even today.

I believe that this is a particular burden for girls. During the first several years of life, girls mature earlier than boys in empathy, language capacity, and brain development. Therefore, it often seems completely unnatural (or even immoral) for a girl to lack self-control, have trouble with school materials, defy teachers, and/or act younger than her age. Because of the importance of social interactions for both girls and women, female peers are particularly apt to dislike and reject girls with the core signs of ADHD more frequently than boys dislike and reject fellow males with ADHD. In short, from both adults and other youth, a particular stigma surrounds girls with ADHD that outstrips such disapproval and denigration for boys.

Because we expect more self-control and social skill from girls, we often judge those who fall short due to ADHD more harshly than boys with ADHD.

Then It Was a Disorder of the Brain . . .

Over time, professionals have emphasized different aspects of the underlying behavior patterns as the core symptoms, applying a variety of diagnoses and labels to such patterns. Labels for much of the 20th century focused on such terms as brain injury, brain damage, organic brain disease, or minimal brain dysfunction. Or the terms focused on deficits, as in *clumsy child syndrome*.

Interestingly though tragically, the influenza pandemic of 1918–1919 left millions dead but also survivors who emerged with distinctive problems in concentration, self-control, learning, and other behavioral features that closely resemble what we today call ADHD. As a result, diagnoses such as brain damage or brain injured became common for the next 50 years. The assumption was that any person who could not behave properly in school or work, and who showed erratic problems of self-regulation and focus, must have an underlying

brain pathology. Certainly, as discussed in later chapters (see especially Chapter 4), many ADHD-style behaviors have biological as opposed to exclusively psychological origins. But these diagnoses were used indiscriminately to signal a huge range of problematic behaviors and emotional displays. Even more, because of the untested assumption that brain damage was always the cause, the labels discounted the roles of parents, teachers, schools, and communities at large in shaping an individual child's outcomes.

. . . and Then Back to Behavior

By the middle of the 20th century, there were two opposing trends. One was to soften earlier labels related to brain damage as minimal brain dysfunction, which (as just noted) incorporated many problems well beyond what we currently conceptualize as ADHD. Another was to focus more specifically on the actual motor behaviors of the condition: fidgeting, squirming, being unable to sit still, and the like. As a result, terms like *hyperkinesis*, *hyperkinetic impulse disorder*, and *hyperactivity* took hold. The problem with that approach was that girls don't display these problems to nearly the same extent as do boys, which contributed to insufficient recognition that girls could have this kind of problem. Inattentive symptoms got lost in the shuffle.

A Lag in Development

Intriguingly, a research-based trend emerged in the 1950s to brand the behavioral problems of inattentiveness, forgetfulness, poor impulse control, and overactivity as reflecting an "immaturity syndrome" in children. As it turns out (and is presented as a key point in Chapter 4), what is now termed *ADHD* does in fact denote behaviorally and emotionally immature children and teens. Yet this did not immediately help clinicians or the public recognize ADHD in girls.

The Emergence of ADD—and Then ADHD

Finally, in the 1970s and 1980s, Canadian psychologist Virginia Douglas proposed that the inability to "stop, look, and listen" was the core of the condition. In other words, at its foundation were difficulties in attending to the environment, restraining impulses, considering the actual contingencies of the situation (at home, in the classroom, in peer groups), and adapting one's behavior to the context at hand. The American Psychiatric Association therefore branded

the condition as ADD (attention deficit disorder), which may or may not be accompanied by hyperactivity. Thus, the terms *ADD with hyperactivity* and *ADD without hyperactivity* were born. Not so many years later, the awkward term ADHD took hold, with the explicit suggestion that both attention deficits and hyperactivity could be present. Note that today many people, including health and mental health professionals, use the terms *ADHD* and *ADD* interchangeably. They are actually the same thing, although ADD can now often refer to the inattentive symptoms without the hyperactive/impulsive ones.

How Is ADHD Defined?

In the latest versions of the classification systems used in the United States and in other countries, ADHD is held to be composed of the following:

- Extremely high levels of inattentive/distractible/forgetful behaviors, typically leading to poor follow-through and poor rule-following at home and school
- Extremely high levels of acting before thinking about the consequences of the action, choosing the first response rather than considering a range of responses, interrupting others, excessively fidgeting, and having trouble containing the desire to keep moving
- Or both of the above

Children and youth with exclusive inattention/disorganization are branded as having the *inattentive presentation* of ADHD (ADHD–Inattentive), those with exclusive hyperactivity/impulsivity as exhibiting the *hyperactive/impulsive presentation* (ADHD–Hyperactive/Impulsive), and those with both symptom domains as having the *combined presentation* (ADHD–Combined). The hyperactive/impulsive form shows up mainly in preschoolers and overwhelmingly in boys. As highlighted throughout this book, girls are more likely than boys to display the inattentive form. Still, many girls with ADHD display considerable impulsivity as well as inattention and disorganization.

Official diagnostic guidelines specify that a girl (or a boy) must show a requisite number of symptoms of inattention and/or hyperactivity/impulsivity for at least half a year, with some of them appearing before age 12. Those symptoms must interfere with the child's development or with functioning in

at least two domains of life, such as at home and at school—or in social interactions and at school.

If your daughter fits the picture of inattention, she may have a really hard time following directions. She may not remember what she's supposed to do at home or school, even when it would be ingrained in other kids because of the routine. She might seem to focus on almost anything other than what she's supposed to be focusing on (like homework, or what you're telling her about a weekend outing)—in other words, she seems extremely distractible. Commonly, she loses things and her surroundings are far from organized. Although she "gets" the content of many if not most of her school subjects, she typically gets worse grades than she should because of a lot of careless mistakes (in other words, she may see the forest but misses out on a lot of trees close by). Finishing tasks is a major headache, for her and you, as well as her teacher(s). Although she is typically highly engaged in activities she likes or at which she thrives, motivation seems to flag quickly when there are many steps to a chore or assignment—or the timeframe is relatively long for completing it. Girls with the inattentive form of ADHD often show many (or even all) of these patterns, but they aren't as active, dangerous, thoughtless, impulsive, or rude/bossy as those who score high on the hyperactive/impulsive group of issues.

So, what do these hyperactive/impulsive behaviors look like? If your daughter fits this pattern, you might be seeing, first, a lot of movement: squirming while seated, leaving the dinner table repeatedly, tapping feet/hands or otherwise keeping in a kind of constant motion, or showing a real physical energy to climb or simply move fast. (*Note:* As highlighted later in the book, girls may be more prone than boys to be more hyperverbal than hyperactive per se.) In fact, impulsive behaviors include real difficulty waiting in line, frequent interrupting of others, answering in class (or on test questions) immediately—without giving full thought before responding, making lots of noise during supposedly quiet activities, and sometimes doing dangerous things for the fun or thrill of it.

It's rare for a child above the age of 5 or 6 to display high levels solely on this second list of hyperactive/impulsive symptoms. That is, once they are in grade school, the combined form of ADHD involves lots of inattentive *and* hyperactive/impulsive behaviors.

It is extremely important not to diagnose children and teens simply because they display high levels of these problems: They also need to be

experiencing considerable life problems as a result. These impairments at home and school are probably what brought you to this book, and any clinician you see should consider diagnosing your daughter with ADHD only when the problems yield real mismatches with the behavioral standards of home life, classrooms, or relationships with peers. Furthermore, the symptoms should not be attributable to other serious conditions (such as depression), even though such conditions may well exist alongside ADHD.

Impairment should be considered more important to diagnosis than the number of ADHD symptoms.

Problems with the Diagnostic Criteria—Especially for Girls

You can probably tell at this point that diagnosing ADHD is no simple matter. That's why you need a well-qualified clinician to evaluate your daughter (as described in Chapter 2). But be aware that there are a few glitches in the current diagnostic criteria:

- *The requirement that symptoms must appear before age 12 can really penalize girls—because for many girls with really impairing ADHD these issues don't emerge fully until middle school and beyond.*
- *Calling this a disorder of attention is incomplete and misleading.* The key problem for those with ADHD is not poor attention per se but a fundamental difficulty in *regulating attention as the demands of a given task, project, or situation shift.*

For example, ever heard of *hyperfocus?* This is a state in which one has real trouble coming back to earth when deeply engaged in a set of thoughts, a highly motivating project, or a video game, often for hours at a time. Many individuals with ADHD, *especially girls and women,* can focus quite well—or even hyperfocus—on tasks or activities in which they are inherently interested. But for rote or boring tasks, or those requiring extensive planning and organization, their interest, attention, and engagement quickly fizzle out. So, ADHD isn't a simple problem of not being able to focus or pay attention. Instead, it's a higher-order issue reflecting the ability to *regulate* or modulate one's effort, focus, and attention (hence the terms *poor self-control* or *poor self-regulation*).

• *Assessments focusing on any specific individual tests may miss the mark because individuals with ADHD tend to be "consistently inconsistent" across a wide range of tests.* Scientists have been using all sorts of cognitive tests and tasks in research studies to help pin down the problem. (Aha! ADHD is a deficit in "selective attention" or "sustained attention" or "the ability to resist distraction," and so on.) But summing across these studies reveals that those with ADHD are not inevitably worse on any particular cognitive or attentional task. Instead, their performance is highly variable and erratic over repeated trials on many different tests and measures. In short, people with ADHD have major issues with lapses in motivation and attention, which means their performance can easily vary from situation to situation or time to time. So, it's not one particular kind of task on which their highly variable performance is an issue; it's on several. People with ADHD waver between attention and distraction, focus and noninterest, on-task behavior and lapses in performance. If your daughter truly has ADHD, her underlying performance is likely to be erratic, for reasons that are not under her (or your) immediate control.

• *Almost all of the information gathered on ADHD is based on studies of boys.* Hovering over all of this is the fact that just about all of the information on ADHD, and what constitutes its essence, comes from thousands of studies that involve either all boys or extremely high ratios of boys to girls. As a result, we are not positive whether the trove of information on ADHD from the history of research on the topic truly applies to females. This goes not only for the kinds of problems they display but also for underlying issues such as brain mechanisms and other forces that may drive their chances for positive or negative outcomes. My own research team, in parallel with others, has pioneered intensive studies of the behavior patterns, life problems, underlying causes, treatment responses, and long-term outcomes of girls with ADHD. Throughout this book, I attempt to intersperse our wisdom and our findings into the information provided.

In the end, understanding female ADHD is essential if our knowledge base is to grow, so that information for you as parents—and for educators, clinicians, and the general public—isn't based on exclusively male-related facts and theories. Only by understanding ADHD in girls and women can health care professionals begin to assess and treat it accurately in females.

How Prevalent Is ADHD in Girls Compared to Boys?

This is not as easy a question to answer as you might think. The answer depends on how ADHD is measured and defined (and the contexts in which it exists), what kinds of samples are studied (those coming to clinics or those in the general population), and the kinds of ADHD symptoms in question. See the box on pages 14–15 for details. We still have not perfected how we study the incidence of ADHD, and how the rate in girls precisely compares to that in boys, but we are making headway.

Even so, I believe that during childhood more boys than girls do have ADHD. Most surveys done throughout the 20th century—especially when the surveys were of youth in treatment of some kind—revealed 5:1, 10:1, or even far higher boy:girl ratios. Not only were the samples biased (for example, boys have higher rates of associated aggressive behaviors than girls, and it's typically such behaviors that get a child referred for assessment and treatment), but there was little or no differentiation of inattention from hyperactivity/impulsivity in rating scales until 1980, when the concept of ADD took hold.

The research deck is stacked toward identifying boys with ADHD.

Things have changed in recent years. Symptom lists are now divided into inattentive versus hyperactivity/impulsivity items, and population-based surveys have become government priorities and are performed more regularly. Also, awareness has risen in health professionals and the general public alike that ADHD in girls is a reality.

Accordingly, national surveys of random households with respect to ADHD show a smaller, but still male-dominated, boy:girl ratio of between 2:1 and 2.5:1. The National Survey of Children's Health (NSCH), a random sample of 100,000 families contacted by phone and repeated every few years, is one significant example. In 2003, for the first time, ADHD-specific questions were included in the survey, inquiring about children in the household between 4 and 17 years of age. Specifically, the parent was asked whether the child had a current diagnosis of ADD or ADHD. The question was then repeated about whether the child had *ever* received such a diagnosis. Of course, we cannot know if the diagnosis was made accurately, but it reflects current professional

Why the Difference in the Rate of ADHD between Girls and Boys Is Difficult to Measure Accurately

Here are some of the reasons that the differences in prevalence between boys and girls are hard to measure with complete accuracy.

- Measures and cutoff points are floating targets. (1) We have few objective measures of brain or bodily processes linked with ADHD to add to reports of observations by parents and teachers. (2) We're also looking at a condition that is not in a "yes or no" illness category (like cancer) but instead represents extreme scores along a continuum—of inattention and/or hyperactivity/impulsivity for ADHD. (3) The precise number of symptoms used to determine the presence of ADHD is an educated guess. Interestingly, good evidence exists that when observing objectively similar levels of ADHD behaviors in boys and girls, adults attribute those problems to ADHD far more for boys than they do for girls. In other words, the very rating-scale measures used to assess ADHD may be biased.

- Let's take the example of two 9-year-old girls. Amanda has the requisite number of ADHD symptoms, but does not exhibit significant impairment, because of her strong cognitive abilities, along with good family and classroom supports. She can't therefore qualify for a diagnosis. Lizzy, with the exact same symptom counts, is seriously compromised academically by problems in learning, her overly rigid school setting, and her lack of structure at home regarding homework expectations. She therefore receives a clear diagnosis. The point here is that with respect to ADHD—along with just about all other mental health, learning, and neurodevelopmental conditions—the symptom counts exist in contexts (home, school, community), as well as cultures, all of which play a huge role in shaping the way the symptoms are displayed and appraised. The same contexts can either exacerbate impairments or foster resilient functioning.

- Research samples don't accurately represent the general population. For practical purposes, many studies use children in clinical settings, who tend to be the ones with the worst problems, or those with families who can afford services, or those who differ in other important ways from the rest of the children who would meet diagnostic criteria. They don't really represent the general population. It has taken a long time in the United States for estimates of ADHD in boys versus girls to benefit from studies of non-clinically-referred children, truly representing the population.

- Until recent years, the two symptom domains have not been separated out in research. Because girls in the general population display considerably lower rates of hyperactive/impulsive behaviors than boys, but with relatively equivalent rates of inattention, failing to separate the two domains means not truly representing girls.

practices. If the answers were "yes," the follow-up question was whether the child or adolescent had ever received medication for ADD or ADHD. Some interesting findings from the NSCH are in the box on page 16.

Is This a True Sex Difference?

In short, current information confirms that ADHD occurs more often in boys than in girls, although the difference is not as great as once thought. Without reliable biological measures, however, we still can't be sure that these findings aren't related to an ongoing bias toward identifying males. I believe nonetheless that the numbers are reasonably accurate. Here's why:

- *A higher rate of ADHD among boys is consistent with the higher rates of other neurodevelopmental disorders among boys.* Neurodevelopmental disorders, like ADHD, typically start early in life and involve core issues in cognitive, social, and behavioral deviations and delays. Other neurodevelopmental conditions include autism spectrum disorders, Tourette syndrome, many learning disorders, and—in the views of some—early conduct disturbances that involve frank defiance and aggressive behavior from a very early age. Taking a broad view of many relevant studies, boys display higher rates of all such neurodevelopmental disorders. Overall, the first 10 years of life constitute the risk period for boys with respect to the onset of neurodevelopmental conditions, including ADHD.

- *Girls exhibit faster brain development in early life than boys do, and boys have higher rates of conditions that reflect their slower development.* As noted earlier, over the first few years of life, girls show higher levels of behavioral control, empathy, impulse control, compliance, and language development than boys. So, it stands to reason that conditions involving social awareness and

What We Have Learned about ADHD in Girls from the NSCH

- Between 2003 and 2012, the percentage of all children ages 4–17 who had ever been diagnosed with ADHD, per parent report, climbed 41%!
- Specifically, by 2012, 11% of all children had received a diagnosis—which is one in nine (and well above rates in just about every other country on earth).
- The boy:girl ratio was about 2.3:1.
- By 2012, and now replicated in other large surveys, lower-income youth slightly outnumbered middle- or upper-class youth and Black children and adolescents slightly outnumbered White children and adolescents. Things have changed since the early days of the "Tom Sawyer" syndrome of the ADHD diagnosis being reserved almost exclusively for White, relatively affluent boys.
- By the time of the 2016 survey, the age range of the children had been extended to 2–17 years. Of course, very few 2- to 3-year-olds get diagnosed with ADHD. The numbers stayed at or just above the 2012 levels. The boy:girl ratio remained at about 2.3:1.
- *For the time being, girls are receiving diagnoses far more than they did a generation or two ago.*
- Finally, what's also intriguing about the NSCH data is that in the rising rates of ADHD diagnoses, for both boys and girls, there is a massive state-by-state variation. In some states (mainly in the South and Midwest), rates are two to three times higher than in the far West. There could be many factors involved here, but at least one pertains to whether states prioritize public-school test scores at all costs. It is just those states that witness the largest increases in rates of ADHD diagnoses, especially for the poorest youth in the state. Policies emphasizing academic performance at all costs may help to increase the pressure to diagnose ADHD.

language development (autism), self-regulation (ADHD, early conduct disturbance), and motor control (Tourette) show higher rates in boys than in girls. In all, the first decade of life is the risk period for boy-dominated neurodevelopmental conditions.

An important note: During the second 10 years of life, girls skyrocket ahead of boys with respect to emotional (sometimes called "internalizing")

disorders like depression, serious anxiety, eating problems, and self-harm. This is a big story, which I discuss in more detail later in the book. Yet it is of real relevance to girls with underlying ADHD, as their risk for such internalizing problems is markedly enhanced during the crucial teen years, over and above rates for other adolescent females.

Finally, and intriguingly, the sex ratio with respect to ADHD becomes much closer to even by adulthood. In other words, just about as many women as men qualify for an ADHD diagnosis. This is a fascinating puzzle, which I consider in later chapters.

Why Were Girls Overlooked Regarding ADHD for So Long?

I learned as a graduate student back in the 1970s and 1980s that ADHD was basically a male-only condition. This was the professional and scientific standard. Indeed, the very rating scales used by parents and teachers to detect behavioral and emotional problems in children were typically loaded with "ADHD" items emphasizing overt hyperactivity and behavioral impulsivity rather than inattention per se. As I've already noted, girls are more likely than boys to have the exclusively inattentive type of ADHD, and these scales did not adequately represent relevant symptoms in girls. These inattentive-type symptoms are also rather "quiet" in classrooms, meaning that they're less disruptive and noticeable to teachers. When they are noticed, they are often believed to emanate from depression or anxiety.

But there is more to the story than this.

The problem of major male overrepresentation in research and clinical recognition goes far beyond ADHD. In fact, even basic animal research on physiology and behavior is biased toward males in a whole range of species. In humans, medical studies of cardiovascular disease, and resultant heart attacks, were so focused on men that there simply wasn't enough information to understand the potentially different risk factors and interventions that relate to women.

In the early 1990s, the U.S. National Institutes of Health began to require that all research studies funded by the various institutes—ranging from cancer to pulmonary disease, from infectious illness to mental disorders—include females to the greatest extent possible. Parallel guidelines then emerged for inclusion of children and adolescents, as well as socioeconomically and racially diverse samples. Without full representation, our scientific models and clinical

practices will simply be off-base. Yet progress has been slower than hoped. Established biases, plus long-held beliefs that male sex is the sole standard, are hard to break.

Girls have truly suffered in silence for far too many years. We still have a long way to go, but things are finally changing.

What Does ADHD in Girls Actually Look Like?

A number of girls with ADHD qualify for the combined form of the condition, meaning that they show lots of inattentive *and* hyperactive/impulsive symptoms. These are the girls most likely to display oppositionality and defiance, with problems not only in school but also with their peers (who may be bewildered by their intrusive, bossy, and seemingly insensitive style) and with authority figures. My team and I have worked with a large number of girls with ADHD over the years, and many mirror the kinds of defiant, ornery, "my-way-or-the-highway" stances of boys. But even here, subtle but important differences are apparent:

- Hyperactivity in girls is much more likely to appear as mental restlessness than the types of physical restlessness that boys experience. Your daughter might feel like she can't slow her thoughts down or get them into some linear configuration.

- Instead of the overly active movements of boys, girls with combined-type ADHD are prone to exhibit overly intense verbal behavior. Your daughter might constantly interrupt others or seem to believe that her views are the only ones worth stating. These symptoms should be emphasized in the assessment of girls and women, over and above physical manifestations of impulsivity and overactivity per se, which are the hallmarks in boys.

Yet even more, as noted earlier, girls are simply more likely than boys to present with the inattentive symptoms of ADHD as the main or even exclusive feature. These, as it turns out, are important factors in the long-term outcome for girls with ADHD.

Even when girls have the "same" ADHD symptoms as boys, the manifestation of those symptoms can be very different.

What Happens When Girls with ADHD Grow Older?

It's important to note, first, that until relatively recently, we simply haven't known about the long-term outcomes of girls with ADHD, because of the lack of recognition of girls with this condition—which greatly curtailed any research at all with females, and particularly any research beyond childhood. However, a number of small investigations, and two much larger ones, have finally provided some guidance with respect to expectations for outcome:

- On average, girls with carefully diagnosed ADHD continue to struggle with academic performance as well as many cognitive functions, relationships with peers and adults, self-concept, and need for additional services. They are also prone to experiencing additional psychological, behavioral, and emotional problems into adolescence and adulthood.
- Evidence is conflicting as to whether girls with ADHD, as they grow older, have higher rates of substance abuse and eating disorders than their typically developing peers. Some girls, however, clearly show such risk.
- Strong evidence is now emerging that girls with ADHD, by adolescence and early adulthood, show a marked tendency toward engaging in self-harm, including frank suicidal behavior. Rates of unplanned pregnancy and poor performance on the job are also strikingly high.

The hyperactive/impulsive symptoms that dominate in boys during childhood may receive a lot of (negative) attention from parents and teachers. These can predict later problems for girls who display high levels as well, especially related to later involvement in aggression and engagement in forms of self-harm like cutting and self-mutilation. Yet it's actually the high levels and high intensity of inattentive problems that predict a range of difficult adult outcomes. Inattentiveness—more precisely, as I've discussed, the lack of ability to regulate attention—is heavily involved in later academic problems, issues with driving, engagement in substance abuse, on-the-job performance, and other difficult issues in adolescence and beyond, including self-harm. Unless we pay careful attention to the attention-related and organization-related problems so characteristic of girls with ADHD, we will miss the boat.

Let's take an example. A young woman with ADHD has been working hard for six months at her job, but realizes that she now has a new shift supervisor. This supervisor soon comments that the young woman is falling behind

on daily reports that need to be made—related to her underlying inattention and disorganization. After the supervisor's critical comment (though it was intended to be helpful), the employee fires off a nasty e-mail reply and texts coworkers, calling out the supervisor's insensitivity. Here, the long-standing attentional problems—accompanied by an overly impulsive, hasty, and defensive retort—have sparked a fast-growing work crisis. Note that the impulsive response may not have been as overtly hostile as one that a male employee might have made, but even the indirect and more subtle lack of restraint escalated the situation.

Furthermore, girls often engage in a lot more behaviors intended to compensate for ADHD symptoms than boys do. You may see your daughter overstudying, refusing to give up, holding to perfectionistic standards, or working day and night. If these habits help her perform well, they might obscure the fact that she has ADHD, at least until the bar is raised in middle school, high school, or college. And what about the costs of such superhuman efforts? Your daughter may end up sacrificing sleep, exercise, mindful eating, and recreation, with accumulated stress bound to take a toll. Also, it's the period between childhood and adolescence when serious issues of anxiety, depression, and even self-harm are likely to emerge for all girls. When ADHD is already present, the risk is even higher.

In all, the factors that make ADHD hard to detect in preteen girls may actually spur difficult and even self-punitive behavior patterns as they mature.

At the same time, however, such major problems are not inevitable. We continue to search for the processes that can drive positive and resilient outcomes. So I close this section with an essential takeaway message. Namely, girls (and women) who get diagnosed with ADHD are *not* all the same. Not only are symptom profiles different, especially between girls with exclusive inattention as opposed to the combined form—but girls bring different temperaments, personality styles, coping mechanisms, family support, and classroom skills to the table. It's a hugely mistaken assumption to categorize all girls with ADHD (as well as all boys with ADHD) as more similar to one another than different from one another. Finding each girl's individual strengths as well as weaknesses, along with the specific actions and activities that "make her tick" or trigger her, are crucial to healthy outcomes. This is an important task for you as her parent and her advocate—even though finding bright spots can seem quite challenging when the family seems entangled in the problems linked to her ADHD. I return to all of these issues later in this book.

So What Do You Do If Your Daughter Has ADHD?

This is the core question for the rest of the book. What can you do to help? To start out, be sure that your daughter gets the kind of evidence-based evaluation outlined in Chapter 2 and that it reveals that she does indeed fit the profile for an ADHD diagnosis. Even though ADHD is not a fixed "box" within which all girls are the same, it probably does mean that your daughter shares a number of characteristics with other girls or teens who fall under this classification.

So you're now on a journey. It will be a long journey, and one for which the outcome can't yet be predicted. But at its outset, here are some issues to confront.

First, you'll need to adapt and change your perspective on your daughter, yourself, and your family. You might initially feel disbelief or denial: *This isn't who my daughter is! She's more than just a diagnostic label.* You might feel anger: *How dare the psychological or medical profession claim that she's just like all those other girls I read about in the press or on social media!?* Alternatively, it might dawn on you that everything you've kept at bay for so long—the suspicion that a longstanding pattern underlying her erratic, underfocused, and troublesome behavior—might actually have an explanation, which could now bring some solace and point to a road toward getting help.

Please remember the concepts of *radical acceptance* and *radical commitment* introduced at the beginning of this chapter. You will need to accept that your daughter is not entirely like many of her peers—and that it will take a lot of work to give her the coping skills that she needs.

Even more, if you're her biological parent, you might come to recognize that her relatives, at least some of them, share similar characteristics. Maybe even you! As I discuss in later chapters, ADHD is transmitted more through shared genes than through environmental factors. If it turns out that you have ADHD, you may inadvertently exacerbate such patterns in your daughter through your own lack of organization and planning, your own issues with anger management, or your own restless and impulsive style. Or through simple frustration over your daughter's differences.

Speaking of parenting styles, it's a mistake to think that negative parenting is the true cause of ADHD (the genetic predisposition is real, as is emphasized in Chapter 4). But it's also incorrect to think that, because genes have a lot to say about an individual's likelihood of developing ADHD, parenting

doesn't matter at all. This is an all-too-common misconception. In fact, even for conditions shaped exclusively by inherited genes, how those genetic predispositions are either fueled or reduced by environments can make all the difference for later thriving.

In other words, for ADHD, where genetics and biology play an indisputable role, parents cannot afford to take on the blame for their child's lapses. Doing so is demoralizing and simply inaccurate. Yet at the same time, it's essential for parents and families (whether biological or adoptive) to take the responsibility to examine their own parenting styles, strive for greater consistency, obtain the best possible support for themselves, and participate in interventions aimed at helping their child's learning and behavioral issues.

More simply: Stop the self-blame, but take responsibility.

At another level, as noted above, you may clearly benefit from trying for a kind of radical acceptance of your daughter's differences. Some of these differences may drive you mad, a lot of the time or even most of the time. But if she finds the right kinds of parental acceptance, nurturance, and support; the right kinds of educational guidance; and the right kinds of strength promotion—she may well gain competence and confidence, with the potential to make uncommon contributions in her life and touch the lives of many others.

The take-home message is this: I don't subscribe to the view that ADHD is an inevitable, hidden gift. In fact, the negative consequences are all too common and, by now, well documented. But I do believe that the kinds of out-of-the-box thinking, intense drive, and ability to go beyond common perspectives and solutions can propel girls with ADHD to make a real mark on the world.

Don't put yourself down, but do take hold of the reins.

Remember to get as much support as you can from families who've already been down this road. Engaging in treatments that have stood the test of time is crucial. We in the scientific community certainly still need to develop, test, and disseminate newer and more effective interventions. But try not to become overly enamored of the "best new thing" you find on the internet, as many such postings are entirely devoid of any scientific basis.

Remember, ADHD doesn't just vanish as your daughter goes through adolescence and makes the gradual transition to adulthood. In fact, it can actually intensify, in both expected and unexpected ways. Best to head things off at the pass, to the greatest extent possible, with treatments that show the best evidence of success. Much more regarding treatments follows later in the book.

Is ADHD All There Is?

This is one of the most crucial questions that you can ask. It's one that directly confronts both those who scientifically investigate and clinically treat girls with ADHD and, of course, all parents dealing with ADHD in their offspring.

A huge amount of research reveals that most girls (and boys) with core problems of inattention and hyperactivity/impulsivity typically have one or more—and sometimes many more—problems that accompany ADHD. More detail on these so-called *comorbidities* can be found in Chapter 2, but here's an overview:

- *Anxiety*. First, there can be significant anxiety, defined as the experience of worry, dread, or even terror without a true threat present. Excessive worrying, a feeling of constant tension, avoidance of situations that seem to trigger the anxiety, fast breathing or rapid heartbeat, and unexplained pain are some key signs of the various anxiety disorders one might experience. Sometimes the sheer stress of having ADHD may trigger anxiety reactions, particularly around school and schoolwork. In other cases, serious anxiety conditions predate ADHD. One of the points of potential confusion here is that a feeling of restlessness can be a sign of anxiety—but restlessness is also a symptom of ADHD. Finally, one of the more difficult issues for a clinician is to make the distinction, particularly for girls, between the inattentive presentation of ADHD and a true anxiety disorder. This kind of "differential diagnosis" (that is, figuring out what belongs where) can be tricky because many girls with inattentive-style ADHD are not at all hyperactive; instead, they are often rather quiet, inhibited, and highly anxious about school and home issues. All this is important because anxiety disorders require different treatment strategies than ADHD itself does.

- *Depression*. Beyond the sadness we all encounter as part of the human condition, major depression involves at least two weeks of out-of-the-ordinary sadness and dark mood (or in some cases a kind of blankness or absence of mood), loss of motivation, repetitive thoughts of self-criticism, sleep and appetite disturbance, and social withdrawal. At its extremes, depression can prompt the belief that life isn't worth living. One of the symptoms of depression is poor concentration, often related to the negative, ruminative thoughts and utterly low motivation the girl is experiencing. So, the clinician will need to tease out what's depression and what's ADHD. Although some preteen girls with ADHD experience depression, the number grows greatly by adolescence, the

time period during which depression takes hold in a large number of adolescent girls. Like anxiety, depression requires different forms of treatment than ADHD, so it's really important to know whether it is an accompaniment.

- *Bipolar disorder.* This is a serious condition in which depressive episodes either alternate with or occur simultaneously with periods of mania, marked by sped-up thinking and behavior, serious impulsivity, fast-shifting moods (during which feelings of elation or superiority can emerge), irritability, and increased motivation for pleasurable events (even if dangerous). The careful reader will notice that impulsivity and irritability can also be a core part of ADHD, so differential diagnosis is especially important here. Bipolar disorder can begin during childhood, but the highest risk period is in mid to late adolescence and beyond. Professionals now know that bipolar disorder can coexist with ADHD. In fact, with a high family "loading" of mood disorders, a history of ADHD in childhood can emerge as bipolar disorder by the teen or early adult years. Medication treatment for bipolar disorder typically involves different primary medications than medications for ADHD, though sometimes the two types of medication can be combined.

- *Oppositional behavior and conduct problems.* Many boys with ADHD—especially those with the combined form, which includes impulsivity and hyperactivity—are hard to manage, defiant with respect to adult requests, and oppositional seemingly whenever limits are set. For a subgroup, such early oppositional defiant disorder can develop into conduct disorder, a far more serious condition involving severe rule-breaking, fighting and other forms of aggression, running away from home, and the like. Girls with ADHD can certainly experience these conditions as well, particularly those with the combined form. More than boys, however, such girls often engage in relational aggression. That is, instead of physically confronting their peers, they may attempt to ruin reputations through the spreading of rumors or "backstabbing" via other means. Think of the potential for such actions to do harm with the fast rise of social media in the past few years. Fortunately, family- and school-based treatments for oppositional defiant disorder and conduct disorder are similar to those that are effective for ADHD.

- *Learning disorders.* Girls with ADHD often struggle with schoolwork related to their inattentive/disorganized symptoms. Yet learning disorders—in reading, math, or writing—have more to do with below-age-expected deficiencies in the underlying language, visual, cognitive, and motor problems related

to literacy or numerical operations. Many girls with such learning disorders are inattentive when they try to learn or practice these skills—because such tasks are inherently difficult for them—but are otherwise relatively self-regulated. As noted above, girls with ADHD show poor attention regulation with regard to a wide variety of requests, beyond school subjects per se. Again, a careful differential diagnosis is essential. Still, a quarter or more of girls with ADHD also experience specific learning disorders. For them, specialized academic programs are needed, beyond evidence-based treatments for ADHD.

- *Posttraumatic stress disorder (PTSD).* I'll take up this topic at more length in Chapter 4, but the key point for now is that when girls have experienced early trauma—not just natural disasters but also including exposure to family or neighborhood violence, physical abuse, or sexual abuse—inattentive and sometimes impulsive problems can emerge. In fact, some critics of an overly biological perspective contend that ADHD is the result of trauma more than of genetic inheritance—and that it would be a great mistake to give medications to such girls on the basis of a careless diagnosis of ADHD. Yet consider the following: (1) ADHD and PTSD can actually overlap, rather than serving as totally distinct entities; and (2) trauma in children can produce physical and brain-related responses. It's not *either–or*; it could be *both–and*. Once more, only a careful diagnostic work-up can distinguish relevant personal histories or make the determination that ADHD and PTSD coexist.

Finally, when adolescence hits, as I've already noted, the teen years can bring on depression or bipolar disorder, more so than in childhood. Other conditions that can emerge in adolescence (if not before), particularly for girls with ADHD, are substance use conditions, eating disorders, and self-harm. I'll save detailed discussion of these until Chapter 9, when we take up adolescent issues for girls with ADHD in much more detail.

Overall, ADHD may well *not* be all that's going on. In the next chapter, therefore, I cover essentials of assessment and evaluation related not only to ADHD but also to such additional areas of concern. I will delve more deeply into what the conditions described in broad strokes here may look like to you and to your daughter's teachers—and how a qualified professional will evaluate your child to ensure that your daughter gets the best help possible. That's always the goal of diagnosis—figuring out how to provide the best possible life for your child.