ADHD IN WOMEN

Comprehensive Evaluation, Differential Diagnosis, Laboratory and Specialized Testing, Medication Management, and Psychotherapy | Clinical Program Guide

Population: Adolescent girls and adult women, with emphasis on adult presentation. **Purpose:** Proposed evidence-based clinical workflow; specialized tests and services require qualified staff, equipment, and referral arrangements. This is not an assertion that every listed service is currently offered.

1. Why ADHD is frequently overlooked in women

ADHD is a neurodevelopmental disorder that may persist throughout adulthood. Many women describe longstanding inattention, disorganization, procrastination, time blindness, forgetfulness, and internal restlessness without conspicuous childhood hyperactivity. Social expectations, compensatory effort, academic achievement despite impairment, and diagnostic overshadowing by anxiety or depression can contribute to delayed recognition. These are common patterns, not diagnostic criteria or universal sex differences.

- **Inattentive presentation:** missed details, unfinished work, misplaced belongings, inconsistent focus, difficulty following multi-step instructions.
- **Executive dysfunction:** chronic lateness, task paralysis, trouble prioritizing, difficulty maintaining household routines and managing bills.
- **Masking/compensation:** excessive lists, overpreparation, perfectionism, working unusually long hours to meet expectations; examine functional cost rather than achievement alone.
- **Emotional and interpersonal concerns:** frustration intolerance, sensitivity to criticism, relationship strain, anxiety and low self-esteem; emotional dysregulation alone is not diagnostic of ADHD.
- **Life transitions:** increased demands during college, employment, parenting, and caregiving may expose previously compensated impairment.

2. Hormonal and reproductive considerations

Some women report changes in attention, mood, sleep, or medication response across menstrual phases, pregnancy, postpartum, or perimenopause. Evidence is evolving and individual variation is substantial. Track symptoms longitudinally rather than assuming a predictable hormonal effect. Ask about menstrual patterns, contraception, pregnancy intentions, lactation, menopausal symptoms, and reproductive safety. Do not automatically change ADHD medication based on cycle phase.

Pregnancy and lactation

Medication decisions require individualized discussion of maternal functional impairment, fetal/infant exposure, available safety data, alternatives, and the risks of untreated illness. Coordinate with obstetrics and pediatrics when appropriate. Avoid abrupt changes without a clinical plan. Screen for postpartum depression, anxiety, sleep deprivation, and bipolar symptoms when indicated.

3. DSM-5-TR diagnostic criteria - clinical summary

For people age 17 and older, at least **five** symptoms of inattention and/or five symptoms of hyperactivity-impulsivity must persist for at least **six months**, be inconsistent with developmental level, and negatively affect functioning. For those through age 16, the threshold is **six** symptoms in a domain. Several symptoms must have been present before age 12, several must occur in at least two settings, there must be clear functional interference, and another mental disorder must not better explain the symptoms. Symptoms must not occur exclusively during schizophrenia or another psychotic disorder.

Inattention symptoms: careless mistakes; difficulty sustaining attention; seeming not to listen; not following through; difficulty organizing; avoiding sustained mental effort; losing things; distractibility; forgetfulness. **Hyperactivity/impulsivity symptoms:** fidgeting; leaving seat; inappropriate running/climbing or subjective restlessness; difficulty engaging quietly; being "on the go"; excessive talking; blurting answers; difficulty waiting; interrupting/intruding.

Presentations/codes: predominantly inattentive F90.0; predominantly hyperactive/impulsive F90.1; combined F90.2; other specified F90.8; unspecified F90.9. Document current presentation, severity, impairment, and partial remission when applicable. These are paraphrased criteria; consult the licensed DSM-5-TR for formal diagnostic application.

4. Comprehensive diagnostic workflow

- **Visit 1 - intake and history:** establish goals; review childhood symptoms, school records, academic/work history, home management, relationships, sleep, substance use, medications, medical conditions, family history, trauma, and prior treatment. Obtain consent for collateral interviews as appropriate.
- **Structured interview:** DIVA-5 or another appropriately licensed adult ADHD interview; systematically document each criterion and examples from childhood and adulthood.
- **Rating scales:** ASRS v1.1 or ASRS-5 for screening; CAARS 2, BAARS-IV, BRIEF-A/BRIEF2A or functional impairment scales when appropriate. Ratings supplement, not replace, clinical diagnosis.
- **Collateral evidence:** partner/family observations, report cards, prior evaluations, performance reviews, and treatment history when available; absence of collateral does not automatically exclude ADHD.
- **Mental status and risk:** assess mood, affect, speech, thought process/content, cognition, insight, judgment, suicidality, mania/psychosis, substance misuse, and functional safety; document only assessed findings.
- **Feedback visit:** integrate data, discuss diagnostic confidence, differential diagnosis, strengths, treatment choices, shared decisions, and measurable goals.

5. Differential diagnosis and comorbidity

Clinical concern	How to evaluate / why it matters
Anxiety and depression	GAD-7, PHQ-9 and interview; distinguish worry or low mood-related concentration changes from lifelong ADHD.
Bipolar spectrum	Assess episodic decreased need for sleep, elevated/irritable mood, increased energy, and risky behavior before stimulants.
Trauma/PTSD	Trauma history, PCL-5 when appropriate; hypervigilance and dissociation can resemble inattention.
Sleep disorders	Sleep duration, insomnia, apnea symptoms, shift work, restless legs; refer for sleep testing when indicated.
Autism/learning disorders	Developmental and educational history; refer for specialist testing when warranted.
Substance use	AUDIT-C, DAST-10 and focused history; assess intoxication, withdrawal, diversion risk.
Medical/medication causes	Thyroid disease, anemia, medication sedation, neurologic disease, perimenopausal symptoms, pregnancy/postpartum sleep loss.

6. Medical assessment, laboratory tests, and other investigations

Core before pharmacotherapy: blood pressure, heart rate, weight/BMI, medical and cardiovascular history, family history of sudden cardiac death or inherited cardiac disease, medication interaction review, sleep/appetite assessment, pregnancy/lactation status when relevant, and psychiatric/substance-use assessment. Baseline labs are **not routinely necessary** to establish ADHD.

Test or procedure	When to consider / objective
CBC; ferritin/iron studies	Fatigue, heavy menstrual bleeding, pallor, restless legs or suspected iron deficiency; investigate anemia.
TSH (with reflex free T4 if indicated)	Thyroid symptoms or clinical suspicion of thyroid dysfunction.
CMP/renal/hepatic testing	Relevant comorbidity, medication selection, or monitoring indication; not universal ADHD screening.
Vitamin B12 / folate	Neuropathy, nutritional risk, macrocytosis, or cognitive symptoms suggesting deficiency.
Pregnancy testing	When pregnancy status is uncertain and the result would affect medication decisions, with informed consent.
ECG / cardiology review	Cardiac symptoms, concerning examination/history, significant family cardiac risk, or other indication; not routine for everyone.
Sleep study	Suspected obstructive sleep apnea or another sleep disorder requiring formal testing.
Urine toxicology	Selective use for substance-related diagnostic uncertainty or controlled-substance risk assessment, consistent with policy and consent; not a diagnostic ADHD test.

Test or procedure	When to consider / objective
Neuropsychological testing	Suspected learning disorder, cognitive decline, brain injury, or complex diagnostic ambiguity; not required for routine ADHD diagnosis.
CPT: TOVA, QbTest, Conners CPT	Optional adjunctive performance measures; cannot confirm or rule out ADHD alone.
EEG / neuroimaging	Only when neurologic signs, seizure concerns, or other specific indications exist; not routine ADHD workup.

7. Medication management - decision process

Choose medication after documenting diagnostic rationale, patient goals, comorbid conditions, contraindications, cardiovascular risk, substance-use/diversion risk, pregnancy considerations, past response, and preference. Explain expected onset, dosing schedule, common/serious adverse effects, missed doses, interactions, monitoring, and when to seek urgent care. Start low, titrate based on response/tolerability and product labeling, and reassess functioning rather than attention alone.

Stimulants - methylphenidate and amphetamine families

Examples: methylphenidate (Ritalin, Concerta), dexmethylphenidate (Focalin), mixed amphetamine salts (Adderall), lisdexamfetamine (Vyvanse). **How used:** select immediate- or extended-release formulation based on daily coverage needs; establish baseline vitals, sleep, appetite, weight, cardiovascular and psychiatric history; monitor during titration. **Goal:** improve task initiation, sustained attention, organization, impulse control, and real-world functioning. **Common adverse effects:** decreased appetite, insomnia, dry mouth, headache, nausea, anxiety/jitteriness, increased pulse or blood pressure. **Important risks:** misuse/dependence, worsening mania or psychosis, and clinically significant cardiovascular events in susceptible individuals. Evaluate emergent chest pain, syncope, severe agitation, or psychosis urgently.

Atomoxetine (Strattera)

How used: daily nonstimulant with gradual titration; benefit typically develops over weeks; assess drug interactions, liver concerns, blood pressure and heart rate. **Goal:** improve ADHD symptoms without controlled-substance prescribing. **Common adverse effects:** nausea, reduced appetite, dry mouth, constipation, fatigue, insomnia, dizziness, sexual adverse effects. **Important risks:** suicidal thinking warning in children/adolescents, rare severe liver injury, increased heart rate/BP, and possible activation of mania.

Viloxazine extended release (Qelbree)

How used: once-daily nonstimulant, titrated by age and labeling; screen for bipolar disorder and review clinically important CYP1A2 interactions. **Goal:** reduce ADHD symptoms when a nonstimulant is preferred. **Common adverse effects:** insomnia, fatigue/somnolence, nausea, decreased appetite, headache. **Important risks:** boxed warning for suicidal thoughts/behaviors in pediatric and adult patients; monitor mood and suicidality, especially after changes.

Guanfacine ER and clonidine ER

How used: alpha-2 adrenergic agonists used for pediatric ADHD; adult ADHD use in the US is off-label. Titrate gradually and monitor BP, pulse, sedation, and dizziness. **Goal:** improve hyperactivity/impulsivity or selected associated symptoms when clinically appropriate. **Common adverse effects:** sleepiness, fatigue, dizziness, constipation, dry mouth, hypotension, bradycardia. **Important risks:** rebound hypertension with abrupt discontinuation; taper as directed. These are not universally preferred adult treatments.

Other off-label options

Bupropion: sometimes considered for ADHD with coexisting depressive symptoms when appropriate; evidence and efficacy are less established than first-line agents. Adverse effects include insomnia, anxiety, dry mouth, nausea, elevated BP; seizure risk is dose- and patient-dependent, and it is contraindicated in seizure disorders and certain eating disorders. Avoid describing antidepressants as FDA-approved ADHD treatments.

8. Reproductive and medication safety planning

- Review pregnancy intentions, contraception, lactation, and patient preferences at initiation and when circumstances change; do not assume pregnancy status.
- Discuss individualized benefit-risk decisions for continuing, modifying, or withholding medication during pregnancy and breastfeeding; coordinate with obstetric and pediatric clinicians as appropriate.
- Assess potential interactions with antidepressants, decongestants, sedatives, and other prescribed or over-the-counter agents. Monitor for activation, insomnia, blood pressure changes, and mood instability.
- For controlled substances, follow current federal/state requirements, PDMP review, documentation, safe storage counseling, and clinically justified monitoring. Avoid automatic assumptions of misuse.

9. Psychotherapy: methods, delivery, and goals

ADHD-focused cognitive behavioral therapy (CBT)

Delivery: typically structured weekly sessions with collaborative agenda, review of between-session practice, identification of automatic thoughts, and skills modules. Teach use of a single calendar, task breakdown, prioritized daily plan, reminders, and graded exposure to avoided tasks. Practice reframing "I always fail" into specific, testable interpretations. **Goal:** reduce procrastination and self-criticism, increase task completion and consistent routines. **Measurement:** weekly completion rate, lateness, missed deadlines, and validated impairment scores.

Executive-function and organizational skills training

Delivery: map a typical day; select one planning system; schedule realistic task blocks; use time estimation, external cues, body doubling or accountability when helpful; practice breaking large projects into next actions; review barriers and adjust. **Goal:** improve initiation, working-memory support, time management, and reliable follow-through. Coaching may complement but not replace clinical treatment.

DBT-informed emotional regulation skills

Delivery: identify emotional triggers and early physiological signs; teach paced breathing, grounding, STOP-type pause skills, distress tolerance, interpersonal effectiveness, and repair after conflict. Use role-play and home practice. **Goal:** decrease impulsive responses and relationship disruption. DBT skills are adjunctive when emotional dysregulation is prominent, not a standalone diagnostic treatment for ADHD.

ACT and self-compassion approaches

Delivery: clarify values, notice unhelpful self-judgments without treating them as facts, practice acceptance/defusion, and translate values into small scheduled actions. **Goal:** reduce avoidance and shame while supporting sustainable, values-guided behavior. Evidence is less established than ADHD-focused CBT; tailor to individual needs.

Interpersonal, family, and couples interventions

Delivery: psychoeducation about executive-function impairments, collaborative division of household responsibilities, explicit communication agreements, shared calendars, and problem-solving rehearsal. **Goal:** reduce conflict and improve predictable support without infantilizing the woman or assigning all responsibility to family members.

Trauma-focused treatment and comorbid psychotherapy

When PTSD, anxiety, depression, or another condition is established, use evidence-based disorder-specific care (for example, trauma-focused therapies for PTSD or exposure-based CBT for anxiety) with appropriate sequencing and safety planning. Do not characterize EMDR or other trauma modalities as primary ADHD treatments.

10. Functional supports and life-stage goals

- **Work and education:** written instructions, reduced-distraction workspace, protected focus blocks, deadline tracking, and consideration of reasonable accommodations based on documented impairment.
- **Home and caregiving:** shared task systems, visual cues, recurring reminders, simplified routines, and realistic delegation; account for unequal caregiving burdens without stereotyping.
- **Sleep and health:** regular sleep-wake schedule, assessment of insomnia and apnea, nutrition and physical activity counseling, and medication timing adjustments when indicated.
- **Relationships:** structured check-ins, collaborative communication, and repair strategies; evaluate intimate partner safety when clinically indicated.

11. Measurement-based follow-up and quality assurance

Initial targets: select 2-4 measurable patient-defined goals (for example, on-time arrival, weekly completed work tasks, reduced missed bills, improved household planning). Record baseline symptom and functional scales. **During titration:** reassess symptom change, functional benefit, sleep, appetite, weight, BP/pulse, mood, anxiety, adherence, adverse effects, and misuse/diversion concerns as indicated. **Maintenance:** periodic review of efficacy, dose, comorbidities, reproductive status, and whether therapy or workplace supports should change. Frequency depends on medication, risk, clinical stability, and law.

Clinical documentation: include chief concerns, evidence for DSM criteria, impairment across settings, differential diagnoses, actual exam/risk findings, reviewed records, treatment options discussed, consent/shared decision-making when established, medication details, therapy actually delivered, and follow-up/safety plan. Do not document tests, counseling, or interventions that were not performed.

12. Practice implementation: core vs optional services

Core psychiatric services	Additional training, licensing, equipment, or referral may be required
Diagnostic interview; DSM-5-TR assessment; rating scales; differential diagnosis; medication management; psychotherapy when qualified; outcome monitoring.	DIVA-5/CAARS proprietary administration; computerized CPT/QbTest/TOVA; formal neuropsychological testing; sleep studies; cardiology, obstetric, and specialty referrals.

References and clinical source documents

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7. U.S. Food and Drug Administration. Prescribing information for Adderall XR, Vyvanse, Strattera, Qelbree, Intuniv, and Kapvay. Consult current product-specific labeling at https://www.accessdata.fda.gov/scripts/cder/daf/

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Clinical note: References support a program framework; check current FDA labels, state prescribing requirements, and instrument licensing before implementation.