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Walden University

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral study by

Beth Walters

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2020

Abstract

Exploring How Clinical Social Workers Screen Women for ADHD

by

Beth A. Walters

MEd, Lesley University, 2005

MSW, Simmons University, 1989

BS, Lesley University, 1983

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Social Work

Walden University

August 2020

Abstract

Women with attention-deficit/hyperactivity disorder (ADHD) are often overlooked in clinical mental health settings. If social workers do not screen their female clients for ADHD, then the theory of distributive justice inherent in the National Association of Social Worker's code of ethics would suggest the women they see in clinical mental health settings are not receiving the services they need and deserve. Yet, little is known concerning how clinical social workers screen adult female clients for ADHD. The purpose of this qualitative study was to explore how licensed independent clinical social workers in Massachusetts screen for ADHD in the women they see in private practice. The participants were required to have a master's level social work designation. Data were collected using 6 clinical social work participants who were selected using a purposive sampling procedure. Data were collected using a 5-item semistructured interview schedule. NVivo computer software was used to transcribe, organize, and analyze the data. Thematic analysis using a grounded theory approach was used to identify common themes from the data. The findings indicate that clinical social workers in private practice do not formally screen female clients for ADHD using a reliable and valid screening instrument. The implications of this study for social work practice determined gaps which currently exist that account for discrepancies in the lower number of adult women with an ADHD diagnosis than their male counterparts. Social change will be achieved when more females are properly screened, diagnosed and treated in larger numbers for ADHD.

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Dedication

I would like to dedicate this capstone project to my late mother, Patricia A. Walters. Mom, your encouragement and belief in my ability to academically achieve as a woman with both ADHD and a learning disability is something I carry with me every day.

Acknowledgements

I would like to acknowledge my beloved husband, Mark Doyle, who was with me every step of the way. From spending precious Sunday afternoons editing, to delivering your famous grilled cheese sandwich to me at my desk late into the night, to taking over all weekend chores while I sat glued to my chair writing, to your endless expressions of love and pride, I will always be grateful. To my children, Seamus, Hayley, and Aidan, your words of encouragement and visits to my office to help break up the day have been incredibly appreciated.

To Dr. Martha Markward, the encouragement and expertise you offered was instrumental to the finish of this project. I am so grateful and blessed to have had you as Chairperson. To Dr. Lewinson, your love of and expertise in qualitative research shows through in your writing and in your instruction. I am grateful for your help.

To the participants in this study. This study could not have been possible without your help. As social workers, we work to promote social justice every day and by doing so, we often have to take risks. Thank you from the bottom of my heart for putting yourselves "out there."

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Section 1: Foundation of the Study and Literature Review

There is a problem in clinical mental health settings where women are seeking help for symptoms that might be associated with attention-deficit/hyperactivity disorder (ADHD) and are not being properly screened (Corbisiero, Hartmann-Schorro, Riecher-Rössler, & Stieglitz, 2017). Clinical social work is a field of practice in social work that applies evidence-based social work theory and practice to screen, diagnose, help prevent, and mitigate bio-psycho-social-spiritual dysfunction (Board of Registration of Social Workers, 2017). The literature suggested that mental health clinicians including psychiatrists, psychologists, and clinical social workers face challenges in screening women for ADHD (Corbisiero et al., 2017). As such, I in this study, I explored how clinical social workers screen women for ADHD. In Massachusetts, clinical social workers are required to have a master's degree in social work and would be first licensed as a licensed clinical social worker (LCSW) to be able to screen clients for a potential mental illness as designated in the *Diagnostic and Statistical Manual* (*DSM-5*). LCSWs may then apply to become an LICSW (licensed independent clinical social worker) after obtaining their LCSW and then receiving 1-year postgraduate clinical supervision to qualify for the highest level of licensure, which is called *licensed independent clinical social workers*. Once these requirements are fulfilled, the social worker is able to qualify for licensure as a licensed independent clinical social worker, which grants qualification to practice mental health screening, diagnosis, and treatment.

In Section 1, I discuss the problem statement, purpose of the study, and research questions, followed by the nature and significance of the study, theoretical framework,

and values of social work relative to the study. Finally, I discuss social injustices and I identify the prevalence of ADHD among adult females. I also address the diagnosis of ADHD including criteria for adult females, outcomes for women with undiagnosed and untreated ADHD, instruments used to screen adults for ADHD, and how clinical social workers screen women for ADHD.

Problem Statement

Clinical social workers must address the psychological needs of women within the mental health setting, yet women with ADHD are often overlooked by all mental health clinicians within this setting (Barkley, 2015; Owens, Zalecki, Gillette, & Hinshaw, 2017; Uchida, Spencer, Faraone, & Biederman, 2018), even though social workers are ethically obligated to address the needs of all (National Association of Social Workers [NASW], 2018), including women with ADHD whose disorder has been undiagnosed and untreated. Given their education, training, and license to practice, clinical social workers should be capable of and responsible for ensuring women are screened for a possible ADHD diagnosis.

In the United States, girls are less likely than boys to be diagnosed with ADHD. For example, 6.5% of girls versus 14.5% of boys younger than 18 years are diagnosed with ADHD during childhood (Black & Benson, 2018). Although this finding suggests females do not experience ADHD at the same percentage as boys, women in considerable numbers are diagnosed in mental health clinics later in life with “late-onset ADHD” (Ahmad, Owens, & Hinshaw, 2019; Fairman, Peckham, & Sclar, 2017; Fairman et al.,

2017), even though late onset per se may merely be the lack of diagnosis in childhood (Quinn & Madhoo, 2014).

The lack of diagnoses of ADHD among girls is troubling because it results in undertreatment, which can have consequences for adult females later in life. For example, women with ADHD are more likely than their non-ADHD female counterparts to be exposed to sexual abuse, childhood physical abuse, and domestic violence; obtain lower levels of education; and have higher rates of poverty, divorce, obesity, and suicide (Fuller-Thomson, Lewis, & Agbeyaka, 2016). Fairman et al. (2017) found the number of women seeking medication for symptoms of ADHD increased from 19/1000 in 2008–2009 to 24/1000 in 2012–2013, when symptoms of adult ADHD were added to the *DSM-5* (American Psychiatric Association, 2013).

In the United States, as many as 60% of all mental health providers are clinical social workers. As such, women whose ADHD has been undiagnosed and untreated are likely to seek help from clinical social workers. Within the context that distributive psychological justice for all clients is achieved when clients are given diagnoses that enables them to access services they need and deserve (Wakefield, 1988), research is needed to show how clinical social workers screen women for ADHD.

Purpose Statement and Research Questions

The purpose of this qualitative study was to explore how clinical social workers in a northeast section of the United States screen for ADHD in the women they see in their private practice. The following research questions guided the research:

RQ1. When clinical social workers see adult female clients in their private practice, how do they determine whether or not a client may have symptoms of ADHD?

RQ2. If a female client has a diagnose that is not ADHD, in what ways do clinical social workers screen for ADHD relative to the diagnosis they already have?

RQ3. If clinical social workers question the possibility of ADHD in female patients/clients, what risk factors, symptoms, and behaviors do they consider in assigning an ADHD diagnosis?

RQ4. What, if any, instrument(s) do clinical social workers use to screen female clients for ADHD?

RQ5. In thinking about how clinical social workers screen adult female clients for ADHD, how do they describe how screening impacts the diagnostic procedure in terms of referring to another professional versus treating the patient themselves?

Key Terms

ADHD. Is described as a neurobiological disorder that presents in childhood and continues throughout adulthood (Barkley, 2015). This disorder is characterized by inattentiveness, impulsivity, and or hyperactivity (Barkley, 2015), and often includes both internalizing and externalizing psychiatric comorbidities (Yoshimasu et al., 2018).

Comorbidity. Mental health disorders that exist alongside other mental health disorders such as ADHD (Jensen & Steinhausen, 2015).

Emotional dysregulation. Expressions of emotion that interfere with goal-directed activity (Thompson, 2019).

Executive functions. Self-actions that are goal directed, accomplish self-control, and maximize outcome, such as working memory and recall, activation, emotional control, organization, activity shifting, planning ahead, and self-monitoring (Barkley, 2015).

Externalization. Behaviors such as oppositionality, aggression, defiance, and argumentativeness (Factor et al., 2016).

Internalization. The unconscious process by which the thoughts, feelings, and attitudes of others are assimilated as one's own ("APA Dictionary of Psychology," 2015).

Need for the Study

The effects of undiagnosed and untreated ADHD on women are seen in the lower attainment of education, employment, interpersonal relationships, and parenting (Quinn & Madhoo, 2014). The review of the literature espoused the need for this study, as evident in the drastic outcomes for women who experience years of low percentages of attainment that are not befitting of distributive justice. For example, 61% of women with a late ADHD diagnosis do not obtain an education past high school (Anker, Bendiksen, & Heir, 2018), 26% of women live in poverty; 47% experience divorce (Fuller-Thomson et al., 2016); and 42% experience suicidality (Guelzow et al., 2017).

Nature of the Study

The nature of both quantitative and qualitative research can provide significant contributions to the practice of evidence-based clinical social work (Lietz & Zayas,

2010). Despite the accessibility of quantitative measures recognizing screening for ADHD in adults, there is a lack of distinguishing research on how clinical social workers screen adult female clients for ADHD, especially when these same discoveries recommend that their indications have likely been underdiagnosed and untreated.

Using a general qualitative design allowed for the exploration of how clinical social workers screened for ADHD in female clients to potentially help mitigate the problem with underdiagnosed ADHD in women. As clinical social workers are within the position to analyze mental health disorders, they were the foremost likely sources with data that were able to give knowledge into whether or not female clients with ADHD are identified and treated in a socially just way within the clinical setting.

I recruited a recommended number of at least six participants (Baker & Edwards, 2012) from private practice settings to participate in the study. The homogeneous nature of clinical social workers, which includes the ability to diagnose mental disorders in the clinical setting, was purposive and offered insight into how they first screened female clients from a variety of backgrounds in the event that a determination of ADHD appeared justified. Once the proposal was approved by Walden University's Institutional Review Board (IRB), recruitment began.

I first sent a letter to the director of the NASW private practice listserv to approve the use of the list serv for initial recruitment. Once approval was granted, I sent an initial email message to the clinical social workers in private practice settings.

I used thematic analysis with a grounded theory approach to give meaning to the data collected from the participants in the study. I reviewed the responses several times

before identifying codes that could be used to identify themes. Once themes were identified, I then reviewed to interpret the meaning in the themes. I examined each theme relative to the overall data collected and then created thematic map of the analysis. In this process, information about screening women overall, as well as by setting and background, became apparent.

Significance of the Study

The demand for empirical clinical social work practice has increased through the years (Basham, 2018). The literature review had identified that although the rate of ADHD diagnosis is increasing in women, it is still not congruent with the percentage of ADHD diagnosis in men. As the current literature suggests, psychologists, psychiatrists, and clinical social workers face challenges in screening for ADHD in women correctly, this study provided the insight needed to begin the process of change by exploring how clinical social workers in a northeast area of the United States screen for and diagnose ADHD in women. The results of this study may hold implications for policy, practice, and future research in clinical social work by better understanding how clinical social workers recognize symptoms of ADHD.

Policy Implications

Identifying how clinical social workers screen adult women for ADHD will be the first step toward understanding what, if any, gaps currently exist that account for the lower percentage of adult women with an ADHD diagnosis as discovered in the literature. If specific gaps are identified, the implication for policy might suggest a mandate for specific training in using an ADHD screening instrument such as the Adult

ADHD Self-report Scale (ASRS-v1.1) (Kessler et al., 2005) as described later in this project. As the literature has called for more objective means of identifying ADHD (Fairman et al., 2017), understanding any gaps that may exist such as not using screening instruments for ADHD would support such policy.

Practice Implications

Services that clinical social workers use in practice with females are essential to their well-being. The findings in this study will provide information on how clinical social workers screen female clients for ADHD. As such, clinical social workers may use this information to ensure female clients are adequately screened for ADHD for them to receive the socially just treatment in the clinical setting that they need and deserve.

Research Implications

The findings in this study may also hold implications for future research. With a better understanding of how clinical social workers screen female clients for ADHD, information about how often they screen female clients for ADHD will be demonstrated. As such, any shortcomings from the existing research might inform future studies of any lack of distributive justice in the mental health treatment planning for women.

Implications for Social Change

Because research is lacking that shows how clinical social workers screen females for ADHD, especially adult females, exploring how clinical practitioners screen for this disorder may result in more females being diagnosed and properly treated for ADHD. Thus, screening can be the means by which females are identified and considered for an ADHD diagnosis. This may result in the correct diagnosis and treatment among females

whose lives have be negatively affected by a previously unrecognized and untreated ADHD diagnosis.

Theoretical Framework

Social justice has long been the driving force that propels clinical social workers to seek perspicuous explanations of social work's core values. Rawls (1971) identified the liberal egalitarian theory of justice. The major proposition in this theory is the fair and socially just distribution of goods and services depends on the lowest common denominator of individual need in society. Intended as a theory to elicit fair and equal social cooperation in the deliverance of goods and services at the macro level, this theory of justice has also been used to explain distributive justice in the provision of mental health services for what Rawls (1971) describes as all persons.

Wakefield (1988) endorsed Rawls's theory as psychological justice wherein clinical social workers apply distributive justice for all clients to receive the diagnoses they deserve in order to receive the services they need. When ADHD among adult female clients is undiagnosed and untreated in the clinical mental health setting, it is socially unjust relative to the negative outcomes experienced by women with ADHD (Wakefield, 1988). Thus, it is essential that service providers in clinical mental health settings screen their female clients for ADHD.

The rationale for using distributive justice is that many female clients in clinical settings may be treated unjustly if there are risk factors for and symptoms of ADHD that go unrecognized. Within this context, clinical social workers who follow the code of ethics are likely to meet the needs of women with ADHD symptoms (NASW, 2018). The

assumption is that clinical social workers screen female clients for ADHD as a means of making a diagnosis and providing clients with social justice in a clinic setting. With regard to the purpose and research questions in this study, the framework supports exploring how clinical social workers screen female clients for ADHD and, in turn, provide social justice.

Values and Ethics

The National Association of Social Work (NASW, 2018) espouses the promotion of core values and principles such as service, social justice, dignity and worth of the person, the importance of human relationships, integrity, and competence. Additionally, the ethical principles established by NASW serve to strengthen and advance sound social work practice. Together, these values and ethics promote high standards of practice which reflect how we protect consumers (NASW, 2018). The NASW code of ethics (2018) expects a logical course progression beginning with the person and emanating out to professional constructs such as values of service, social justice, and clinical competence.

The NASW code of ethics (2017) guides clinical social work practice in several ways. The NASW champions altruism through clinical service directly attributable to contributions toward the greater good and through recognizing and filling in gaps of need. By addressing the gap in knowledge concerning how clinical social workers screen and diagnose women with ADHD, clinical social workers will be better able to address this social problem. The services clinical social workers provide will extend and encapsulate diversity from our micro to macro systems. Social work justice promotes

multicultural values and mitigates the oppression of marginalized populations such as women who have lived a lifetime with undiagnosed and untreated ADHD (Fuller-Thomson et al., 2016).

Clinical competence necessitates knowledge and skills in screening and diagnosing ADHD in women. Clinical competence also discourages complacency. clinical social workers in Massachusetts are required to obtain 30 continuing credit hours every 2 years. These credits help clinical social workers stay abreast of new techniques and skills and are a part of sound ethical practice. Using findings from this study for clinical training will aid in the distribution of knowledge, addressing gaps in clinical social work knowledge. Therefore, the NASW code of ethics' values of clinical service, social justice, and clinical competence serve as the foundation for this research project.

Review of the Professional and Academic Literature

To identify literature related to screening adult females for ADHD, I searched Google Scholar using the phrases *ADHD in women, ADHD-inattentive in women, sex-differences in women with ADHD, clinical social workers screening for ADHD,* and *ADHD screening instruments*. I read the abstracts of articles as well as the full texts where available in Google Scholar. Where the full texts were unavailable, I retrieved the articles from Walden University Library.

The topic of ADHD has been widely studied, and new literature emerges frequently. As such, the parameters for the literature included only peer-reviewed literature published between 2014 and 2019. Although the search yielded significant research articles pertaining to the keywords, distributive justice theory was first proposed

in 1971 and applied to the clinical setting in 1988. The best definition of screening was identified in an article published in 2001.

Prevalence of ADHD Among Adult Females

Owens et al. (2017) noted the estimated male-to-female ratios for ADHD were to 3:1 and used these ratios to determine that nearly 1 million females in the United States experience symptoms of ADHD. The Centers for Disease Control (CDC, 2017) found approximately 13% of men versus 5% of women in the United States are diagnosed with ADHD. However, Anderson et al. (2018) found a 344% increase between 2003 and 2016 in private insurance prescriptions for ADHD medication among women between 14 and 44 years of age, which suggests women with ADHD are being diagnosed at higher percentages than they were before. With this said, the increase in prescriptions to address ADHD among adult females brings into question the issue of adult onset (Agnew-Blais & Arseneault, 2018). However, a study by Ahmad et al. (2019) dispelled the theory of adult-onset by arguing ADHD is a neurobiological disorder inherent in individuals at birth and that symptoms can be identified in early childhood. The researchers showed that adult-onset is merely due to unrecognized symptoms such as inattention which is especially characteristic of women with ADHD. Holthe and Langvik (2017) proposed the symptoms of ADHD in females may simply not be evident until early adolescence.

Magnin and Maurs (2017) attributed a general increase in ADHD diagnosis of 27% for both male and female adult populations to the restructuring of the diagnostic criteria found in the *DSM-5.* In the revision from the *DSM-4* to the *DSM-5* for example, the age of onset for symptoms was changed from 6 to 12 years of age, which is due to the

likelihood that many adolescents and adults were previously unable to recall early symptoms (Adler et al., 2017). This lack of recall disqualified the onset of symptoms required before the age of 6 for an ADHD diagnosis. Another change from the *DSM-4* to the *DSM-5* is that adults must now experience five symptoms instead of six symptoms (Agnew-Blais & Arseneault, 2018), which may also be attributed to the increase of ADHD in women.

Presentation of ADHD Among Adult Females

Quinn and Madhoo (2014) conducted a systematic review to identify the clinical presentation of ADHD in women and girls. The researchers found in both women and girls that the main presentation of ADHD was inattentiveness, which they contended is often overlooked due to internalization as a means of coping with ADHD symptoms. Pam (2013) noted that internalization is the unconscious mental process whereby characteristics, beliefs, feelings, and attitudes of other people are assimilated into the self.

Inattentiveness

It is well documented that females developmentally tend to internalize as a means of coping (Owens et al., 2017) compared with their male counterparts, who externalize via acting out physically and aggressively. Given the tendency of females to internalize as a means of coping with ADHD symptoms, the inattentive component of ADHD is often overlooked. In turn, this often results in anxiety or depression diagnoses (Barkley, 2015; Fuller-Thomson et al., 2016; Holthe & Langvik, 2017; Owens & Hinshaw, 2016; Quinn & Madhoo, 2014). In this regard, Hankin et al. (2016) noted the prevalence of these and other comorbid disorders may be attributed to women internalizing what they

consider to be "their repeated failures," and Owens et al. (2017) illustrates that these perceived failures are intensified for women with ADHD.

Between 1997 and 1999, the Berkeley Girls with ADHD longitudinal study (BGALS) was conducted. The initial focus of this study was to investigate symptoms of ADHD in girls through a period of time in what the researchers believed was an understudied population based on historical tenets that only boys could have ADHD and that ADHD was a childhood disorder which abated over time (Barkley, 2015). Using a group of 140 female participants with an average age of 9.6 years composed of girls already diagnosed with ADHD-inattentive and ADHD-combined and 88 age- and ethnically matched comparison girls, the researchers conducted a 16-year outcome study that examined symptomology, attainment, and impairment of the girls in what was considered waves (Owens et al., 2017). The study consisted of four waves at 5-year intervals. At each wave, the researchers measured ADHD symptoms for diagnostic consistency and validation of ADHD diagnosis and found that inattentive symptoms were consistent among all of the girls throughout the years. This study is particularly relevant as the findings of inattentiveness in ADHD yield ongoing problems for girls into adulthood.

Characteristics of Adult Females With ADHD

The likelihood of young women experiencing symptoms of ADHD into adulthood is great. Fuller-Thomson et al. (2016), in a retrospective study, noted 70% of young women carry ADHD symptoms, especially inattentiveness, into adulthood. The researchers also found 26% of the women with ADHD lived in the lowest 10% income

bracket compared to 13% of women without ADHD. Specifically, 37% of the total population of ADHD women reported they could not meet basic household expenses due to low income level. Thirty-one percent of women with ADHD reported having an episode of major depressive disorder and 35% had a general anxiety disorder. Last, the study showed that during childhood, 36% of the ADHD women experienced sexual abuse versus 11% of their non-ADHD counterparts (Fuller-Thomson et al., 2016).

As poverty, anxiety, depression and higher instances of sexual abuse are some of the characteristics women with ADHD carry into adulthood, Quinn and Madhoo (2014) identified five more characteristics one might see in females as expressions of ADHD. First, some may present with typical symptoms, especially inattentiveness. Second, women with ADHD often appear to have lowered self-esteem due to internalizing a negative self-image and embarrassment over symptomology. Third, women with ADHD experience challenges in peer relationships due to the symptoms of ADHD. Fourth, women with ADHD have higher instances of other mental health disorders. Finally, women are more likely to have experienced risky sexual behavior, which may be influenced by both hormonal fluctuations that impact the symptomatology associated with the ADHD and impulsivity.

Behaviors of Adult Females With ADHD

Quinn and Madhoo (2014) suggested being aware of several behavioral characteristics of women with ADHD is important. For example, there is a high likelihood of a family history of ADHD. The women likely have problems in relationships of all types. The women are more likely to experience risky sexual

behavior, which may be influenced by both hormonal fluctuations that affect the symptomatology associated with ADHD and impulsivity. Last, women with ADHD have a higher likelihood of oppositional defiance disorder and conduct disorder than their non-ADHD counterparts, which may significantly influence both peer and intimate relationships.

Researchers have also noted the prevalence of suicidality among women with ADHD (Kakuszi, Bitter, & Czobor, 2018). Suicidality includes ideation (thinking about committing suicide), behaviors (suicide attempts), and completion (mortality) (Kakuszi et al., 2018a). It is particularly important to understand these adverse outcomes, as both suicidal ideation (Guelzow et al., 2017; Kakuszi, Bitter, & Czobor, 2018) and suicide attempts are more prevalent in women than men with ADHD (Swanson, Owens, & Hinshaw, 2014). Fuller-Thomson et al. (2016) reported that 42% of women with ADHD experience suicidal ideation compared with 21% of women without ADHD. Both suicidal ideation and suicide attempts may be factors to consider in how clinical social workers screen for ADHD in women.

Outcomes for Women With ADHD

As previously mentioned in the BGALS study by Owens et al. (2017), the fourth wave of assessment identified numerous issues among the participants, with inattentiveness as the dominating symptom. When the study first began, Owens et al. (2017) reported that the symptoms of inattentiveness in the girls were initially identified through the Swanson, Nolan, and Pelham Rating Scale (SNAP-4th ed.; 1992). The SNAP scale included questions such as (a) fails to pay close attention to details in schoolwork,

work, or other activities; (b) has difficulty sustaining attention in tasks; (c) does not seem to listen when spoken to; (d) does not follow through on instructions or fails to finish school work; (e) has difficulty organizing tasks and activities; (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort; (g) often loses things necessary for tasks and activities; (h) is often distracted by outside stimuli; and (i) is often forgetful in daily activities. By the fourth wave of the BGALS study, the results showed these inattentive symptoms in the women with ADHD remained the same through time.

Additionally, the researchers concluded the majority of women experienced damaging results in a variety of areas (Owens et al., 2017). At Wave 1, for example, the same researchers found the girls with ADHD were consistent for internalizing behaviors, externalizing behaviors such as aggression, comorbidities such as mood disorders, preexisting speech and language problems, grade retention, and documented abuse in addition to continued symptoms of inattentiveness (Owens et al., 2017). The results of assessment at Wave 2, in addition to continued symptoms of inattentiveness, showed specific externalizing behaviors related to the continued development of the Wave 1 externalizing behaviors such as defiance, being quarrelsome, and having temper outbursts (Owens et al., 2017). Five years later, at Wave 3 assessment, the researchers found the majority of girls continued to experience inattentiveness, and the internalizing and externalizing behaviors also continued (Owens et al., 2017). The girls had higher instances of substance abuse/dependence, eating disorders, and peer conflict; poorer social skills; and lower academic achievement. When Wave 4 was complete, the

researchers concluded ADHD in women included 10 domains reflecting the different maladaptive presentations in women, especially inattentiveness. Additionally, health problems such as increased body mass and susceptibility to at least one unplanned pregnancy were documented (Owens et al., 2017). These findings suggest the need to examine life outcomes for women with ADHD. In the absence of appropriate attention to a history of symptoms, ADHD will likely result in a lifetime of multidysfunctions for women whose symptoms, characteristics, and behaviors may have been overlooked in the clinical mental health setting. These dysfunctions can be seen in education, employment, interpersonal relationships, and parenting (Owens et al., 2017).

Education

Anker et al. (2018) found women with ADHD achieve lower levels of attainment in education. Fuller-Thompson et al. (2016) compared the educational levels of 107 women with self-reported ADHD and 3,801 women without ADHD. The results of this study showed 61% of women with ADHD obtained a postsecondary degree compared with 72% of women without ADHD. In a qualitative study, Hellerod, Anckarsater, Rastam, and Scherman (2015) asked 21 adult female participants with ADHD to describe their experiences of having ADHD. Half of the women acknowledged reduced attainment in school, which they attributed to feelings of decreased value in society (Hellerod et al., 2015).

Hechtman et al. (2016) conducted a longitudinal study with 476 participants diagnosed in childhood with ADHD and a control group of age-matched and sex-matched participants without ADHD. With data collected at 12, 14, and 16-years postbaseline, the

results showed the ADHD group had lower family income and less education, with 61.7% having a high-school degree or less. In comparison, nearly 62% of participants in the control group had completed some college. Although the participants in the Hechtman et al. (2016) study were not divided by gender, Anker et al. (2018) collected data from an equal ratio of women and men with ADHD, and showed similar results; women had less educational attainment than their male counterparts.

Employment

Researchers have indicated women with ADHD achieve lower levels of attainment in socioeconomic status related to employment (Fuller-Thomson et al., 2016). In terms of occupational outcomes, 16% of ADHD participants received public assistance versus 3.2% of participants without ADHD (Fuller-Thomson et al., 2016). Additionally, in the Owens et al. (2017) BGALs study, the researchers concluded the majority of women with ADHD symptoms that persisted into adulthood experienced poorer results in both educational and occupational attainment.

Interpersonal Relationships

There is no doubt that interpersonal relationships are paramount to the survival of human beings, and research through the years has espoused that women are more dependent on relationships for their well-being (Williamson & Johnston, 2015; Yoshimasu et al., 2018). Little is known about whether is associated with female interpersonal difficulties (Babinski & Waschbusch, 2016; Williamson & Johnston, 2015); however, several researchers have begun to identify that inattention and

hyperactivity/impulsivity may add to challenges with life partners, peer relationships, and parent-child relationships.

Ben-Naim, Marom, Krashin, Gifter, and Arad (2017) studied the role of intimacy in having a life partner with ADHD versus intimacy between partners with no ADHD. The researchers used the Marital Adjustment scale developed by Locke and Wallace (1959) and the Intimate Friendship scale developed by Sharabany (1974) to measure marital adjustment and intimacy in the marriage. The results of the study indicated the majority of partners with ADHD scored lower on both scales compared with non-ADHD couples. These findings suggest presentations of ADHD in life partnerships negatively impact the relationship.

VanderDrift, Antshel, and Olszewski (2019) attributed challenges in romantic relationships to a lack of motivation and ability to attend to the details in relationship management found in women with ADHD. The researchers described relationship management as the functions of thinking and behavior associated with maintaining a romantic relationship. In a sample of 55 males and 117 females who were involved in at least a 6-month relationship, the findings suggested that both males and females with inattention and hyperactivity/impulsivity experienced the same rates of relationship dissolution.

For women, the problem of inattention can become especially impairing in peer and intimate partner relationships (Hansson, Hallerödical Anckarsäter, Råstam, & Hansson Scherman, 2015; Quinn & Madhoo, 2014). Quinn and Madhoo (2014) found impaired social behaviors are deficits in reading the social cues of others. These deficits

combined with inattention work against the notion that women tend to be shy, cooperative, and competent listeners (Ahmad et al., 2019; Uchida et al., 2018). As such, overlooked deficits in women with ADHD can result in losing sense of self-worth and well-being (Holthe & Langvik, 2017). In turn, internalization of these losses may result in anxiety and depression (Ucinda et al., 2018).

Parenting

There are opposing views on whether ADHD in women affects parenting skills. Babinski et al. (2016) found mothers with ADHD reported more parent–adolescent conflict, less parental knowledge and monitoring, and less consistent and more ineffective discipline, especially when the mother had a lifetime prevalence of a comorbid mood disorder such as depression. Woods, Mazursky-Horowitz, Thomas, Dougherty, and Chronis-Tuscano (2019) found that ADHD symptoms such as emotional dysregulation or the inability to control emotions influence a mother's anger, resulting in less understanding and fewer positive parent–child interactions. In addition, inattention has been associated with inconsistent discipline (Park et al., 2017). In contrast, several researchers have posited females with ADHD are less dysfunctional in parenting due to compensatory strategies the women develop through the years to reduce symptomology (Canela, Buadze, Dube, Eich, & Liebrenz, 2017; Williamson & Johnston, 2015). Although these studies support compensation strategies, further research might be needed to explore what these compensation strategies are and how these strategies work for some women with ADHD and not work for others.

Screening Adult Females for ADHD

Wald (2001) stated that screening is a systematic inquiry to identify individuals who are at risk of a particular disease or disorder and need further investigation or preventive act. In contrast, diagnosis establishes the presence or absence of a disease/disorder for the purpose of treatment. Mental health screening is a prediagnostic method often using specific self-rating instruments to identify possible disorders where symptoms already exist but have not been formally determined (Corbisiero et al., 2017). Corbisiero et al. (2017) noted that screening instruments are often used to determine symptoms associated with ADHD.

Based on the previous sections in this review, there is considerable agreement that there are women whose ADHD has been overlooked which results in negative outcomes for them and, thus, there is a need for women who seek treatment to be screened for ADHD. In this regard, there is also agreement that women with ADHD present with inattentiveness, which brings into question which items on measures used to screen for ADHD specifically address inattentiveness. In addition to inattentiveness, family background, peer and intimate partner relationships over time, sexual habits, employment, and educational history should be considered in the screening process (Barkley, 2015).

The Adult ADHD Self-Reporting Screening Scale for *DSM-5* (ASRS-5, 2017) is extensively used around the world to screen adults for ADHD and The World Health Organization (WHO) updated the Adult ADHD Self-Reporting Screening Scale to ASRS-5 as a means of calibrating it with the DSM-5 (Ustun et al., 2017). It consists of

six questions useful in screening for ADHD among adults. Of the six questions, the following question best addresses inattentiveness in adult females: How often do you have difficulty concentrating on what people say to you, even when they are speaking directly to you (Ustun et al., 2017)?

Clinical Social Workers and Screening Adult Females for ADHD

Probst et al. (2015) noted that clinical social workers dominate mental health services, estimating approximately 60% of mental health service providers are clinical social workers. This means clinical social workers are in positions to provide women whose ADHD has been overlooked with social justice in the clinical setting if they screen female clients especially for inattentiveness, regardless of comorbid diagnoses. However, relatively little is known about the extent to which clinical social workers screen adult women for ADHD.

In using focus groups and scheduled interviews, Pendleton (2018) examined the factors that influenced the diagnosis and treatment of ADHD among 30 health care providers employed in five clinics. The qualitative data showed health care providers believed they lacked the information and confidence to diagnose and treat behavioral health conditions such as ADHD in the absence of a multidisciplinary team. The one clinical social worker who participated in the study acknowledged that even with her clinical education and training, she felt more comfortable as a member of a team in diagnosing and treating behavioral health conditions.

This brings into question the education and training of clinical social workers. In most states, clinical social workers have a master's degree in social work (MSW) from a

graduate program accredited by the Council on Social Work Education. They usually select the clinical specialty in their graduate study and, as such, are introduced to disorders in the *DSM-5*. Beyond the degree, social workers must become licensed via an examination and have 30 continuing professional education hours within the past 2 years of licensure, and documentation of a certain number of years in paid, supervised, and post-MSW clinical social work employment in an agency that provides mental health assessment and treatment.

Although clinical social workers have the education and training to diagnose ADHD in female clients, Hamed, Kaur, and Steven (2015) noted that comprehensive research may help improve diagnostic rates and treatment of ADHD for all populations. However, before diagnosis and treatment can occur, women whose ADHD may be undertreated or whose comorbid disorders have masked their symptoms of ADHD must be identified (Quinn & Madhoo, 2014). Despite this need for identification of ADHD in female clients, little is known about how clinical social workers screen adult females for ADHD .

Summary

In this section, I introduced the research problem and purpose of the study, the research questions, the terms important to the study, and the need for the study. These introductions were followed by discussions of the nature of the study, its significance, theoretical framework, and relevance to the values and ethics of social work. Last, I documented a review of the literature illustrating what we know about the lack of screening of adult women for ADHD. In Section 2, I will describe the research design

and data collection procedures.

Section 2: Research Design and Data Collection

Many women experience ADHD, yet their symptoms are often undiagnosed and untreated (Corbisiero et al., 2017). Clinical social work is a field of practice in social work that applies evidence-based social work theory and practice to screen, diagnose, help prevent, and mitigate bio-psycho-social-spiritual dysfunction (Board of Registration of Social Workers, 2017). The literature suggests mental health clinicians such as psychiatrists, psychologists, and clinical social workers face challenges in screening women for ADHD (Corbisiero et al., 2017). As such, in this study the purpose is to explore specifically how clinical social workers screen women for ADHD. In Section 2 of this project, I provide an outline of the research design. Following the outline, I will describe the approach to data collection, participant recruitment, and instrumentation.

Research Design

Research is lacking that shows how clinical social workers screen adult females for ADHD. As such, there is a lack of identifiable variables. As the nature of qualitative research aligns with the paradigm of clinical social work client interviews, using a qualitative research design which is naturally inductive would allow for the exploration needed to offer detailed, rich data for this project.

This qualitative study will utilize interviews to explore in what ways, if at all, clinical social workers screen for ADHD among adult female clients. The questions posed to participants will result in answers to the general research questions in the study:

RQ1. When clinical social workers see adult female clients in their private practice, how do they determine whether or not a client may have symptoms of ADHD?

RQ2. If a female client has a diagnose that is not ADHD, in what ways do clinical social workers screen for ADHD relative to the diagnosis they already have?

RQ3. If clinical social workers question the possibility of ADHD in female patients/clients, what risk factors, symptoms, and/or behaviors do they consider in assigning an ADHD diagnosis?

RQ4. What, if any, instrument(s) do clinical social workers use to screen female clients for ADHD?

RQ5. In thinking about how CSWs screen adult female clients for ADHD, how do they describe how screening impacts the diagnostic procedure in terms of referring to another professional versus treating the patient themselves?

This qualitative study utilized interviews to elicit information from participants. Each participant was interviewed in a private location of their choice using the same semi-structured interview protocol to ask each participant questions about how they screen adult females for ADHD. The rationale for using this approach was the need to provide participants with a certain degree of privacy to elicit reliably their responses to questions posed in the interview process.

Two definitions warrant clarification that are especially important to understanding the need to explore how clinical social workers screen female clients for ADHD in a general qualitative study. First, the symptom of inattention as written in the

ASRS v1.1 (Kessler et al., 2005) can be best described as being easily distracted by outside stimuli and troubles with concentration (*APA Dictionary of Psychology*, 2018). Internalization is another symptom in understanding ADHD in women, which is best described as the process by which women view themselves negatively compared to others (*APA Dictionary of Psychology*, 2018).

Methodology

I will discuss three key aspects of the methodology: (a) participant recruitment (b) prospective data, and (c) instrumentation.

Participant Recruitment

I used a purposive sampling procedure to recruit clinical social workers to participate in this study. Although there are no steadfast rules for sample sizes in purposive sampling, the tendency is to aim for a lower number of participants to enable deep connections to the data being collected (Vaismoradi et al., 2013). Baker and Edwards (2012) suggested at least six to 12 participants would be adequate for a study of this nature. Ritchie and Lewis (2003) also suggested that small samples will provide enough evidence to reach saturation in qualitative research. Ultimately, the sample size for this project was six participants and was determined by reaching saturation when there was no new data, codes, or themes which emerged from participant interviews (Fusch & Ness, 2015).

The sample of participants was identified from social workers who engaged in private practice. At the time of this study, there were 75 clinical social workers in Massachusetts who were licensed to provide independent clinical social work services in

a private practice setting and who were members of a state chapter of the NASW private practice specialty group in the northeastern United States. I sent an email to the director of the listserv asking for her consent to use the listserv to recruit potential participants.

Eligibility requirements for clinical social workers included an MSW from a program accredited by the Council on Social Work Education; 30 contact hours of post-MSW continuing education within the past 2 years before licensure; and 3 years of paid, supervised, and post-MSW clinical social work employment. Each clinical social work practice setting provided mental health assessment and treatment services, and each clinical social worker possessed a current Massachusetts clinical social work license. Each participant was a member of the NASW Massachusetts chapter and, as such, adhered to the NASW code of ethics (Board of Registration of Social Workers, 2017, p. 3).

With permission from the listserv manager, I sent an e-mail message to the members of the state's NASW Private Practice listserv to inform them about the capstone project. The e-mail provided members with a brief description of the research project and its importance as well as to invite them to participate in the study.

For the clinical social workers who expressed interest in participating in the study, I sent an additional email message thanking them for their interest along with both an informed consent and a demographic questionnaire for their review. If the participants believed they understand the study well enough to make a decision to participate, they were asked to indicate their consent by replying to the email with the words "I consent." A follow-up email was then sent to each potential participant to

arrange a meeting in a private location of their choice such at their work office as well as a time for their interview. Most of the participants had previously filled out their demographic questions but for those who did not, a copy was brought to the interview for completion prior to the interview. Once completed, the interview commenced, and I collected the data during a 1-hour face-to-face digitally recorded interview.

Prospective Data

I collected data from six participants using a semistructured interview guide to identify the ways they screened for ADHD among female clients. I interviewed the participants in a private location of their choice and at a time that was convenient for them. This process ensured the privacy participants needed to feel confident that their responses would private. Each interview lasted approximately 1 hour and was recorded using a digital voice recorder.

Instrumentation

The instrument in this study was 5-item semistructured interview guide asking participants to share their thoughts in response to the following questions (see Appendix E):

1. When you see adult female clients in your practice, how do you determine whether or not they may have symptoms and background that make them at risk of having ADHD?
2. If a female client has a diagnosis that is not ADHD, in what ways do you try to identify ADHD relative to the diagnosis she already has?
3. If you question the possibility of ADHD in your female patients/clients, what

risk factors, symptoms, background, and/or behaviors do you consider in determining if an ADHD diagnosis seems warranted?

4. What, if any, instrument(s) do you use to identify female clients for ADHD, and what items do you think are most important in considering the need to diagnose the client with ADHD?
5. In thinking about the ways that you might identify ADHD in female clients, how would identifying for ADHD impact the diagnostic procedure in terms of your referring the client to another professional for diagnosis and treatment versus diagnosing and treating them yourself?

The same questions were used for all participants. The rationale for using a semistructured interview allowed for a more descriptive and relaxed narrative to take place, while at the same time provided a measure of consistency across interviews.

Data Analysis

I used NVivo 12.5.0 computer software (QRS International, 2019) to organize, sort, and analyze the qualitative data collected in this study (Maher, Hadfield, Hutchings, & de Eyto, 2018). Each interview was digitally recorded, transcribed into text, and then uploaded into NVivo. The researcher was the instrument for analysis and, as such, established rigor and trustworthiness through thematic analysis to create the knowledge needed for practitioners (Nowell, Norris, White, & Moules, 2017).

Thematic analysis with a grounded theory approach was applied during the data analysis phase of this research which permitted a systemic and a more critical view in determining the themes that arose from the data collection (Creswell, 2007). Using a

grounded theory approach relied on three steps needed to develop succinct categories to use as themes for thematic analysis, which ultimately answered the research questions asked in this study (Corbin & Strauss, 2014). The first step was completed by reading and rereading the text and then assigning nodes to segments of the data to begin to understand the raw data. In NVivo software, codes are called “nodes.” The second step, axial coding, was used to identify the relationships between the nodes and these nodes began to inform concepts within the data (Charmaz, 2006; Corbin & Strauss, 2014). Once these relationships or concepts were identified, categorical coding was selected as the third step. The researcher then reviewed the categories and established a shared meaning which reflected the data from participants. These categories were then organized into a thematic map to establish homogeneousness, and the most prevalent themes were used to answer the research questions.

Although a priori was not specified in advance of data analysis, several factors had been identified as important to be considered in screening women for ADHD. Those factors were (a) inattention, hyperactivity, and/or impulsiveness, (b) family background, (c) peer/intimate partner relationships over time, (d) sexual habits, and (e) educational and employment histories.

Trustworthiness

Demonstrating rigor in qualitative research can best be done using trustworthiness as a criterion for evaluating qualitative studies (Maher et al., 2018). To establish trustworthiness, it is important to include criterion such as credibility, transferability, dependability, confirmability, and validation (Ravitch & Carl, 2016). Using these

constructs enabled the researcher to follow the prescribed steps to ensure that the rigor demanded in qualitative research was met (Cypress, 2017).

First, credibility was established in this study via triangulation of the participants responding similarly to the research questions. Credibility was instituted by member checking on the initial analysis. Member checks are useful for obtaining approval and trust from the participants (Thomas, 2017). This was completed by emailing copies of the transcripts to the participants for their review to provide an opportunity to verify their statements and fill in any gaps from their interview. Three participants chose to respond to the email. Second, dependability was established in the approval of a panel of experts (i.e., doctoral committee) that the raw data identified in the responses of participants supported the findings in the study and could be identified by the use of an audit trail. The audit trail was established by keeping records of the raw data, the field notes taken during data collection, member checking after the data was transcribed into text, the transcripts from NVivo, and the notes created in analytic memos during the coding process. Third, transferability was seen in thick descriptions from the data collected in this study which might be used in future studies. Confirmability was established using the same interview script for each participant to ensure that the outcomes of data collection were the perceptions and experiences of the participants. Lastly, after each interview, an in-interview member check was obtained by confirming what was said by the participants via the interview notes.

Ethical Procedures

Walden University's IRB approval number for this study is 01-23-20-0746322. Several ethical dilemmas cited as being specific to qualitative research methodology were considered for this study; privacy, informed consent, and economic risks (Sanjari et al., 2014). The Director of Clinical Practice at the Chapter for Private Practitioners in Massachusetts was contacted via e-mail to obtain the permission needed to use the listserv that contained the names of potential participants. Participants were interviewed in a private location of their choice to ensure that their responses would not be overheard. Prior to beginning the interview, each participant confirmed their informed consent and status as a clinical social worker through a demographic questionnaire. Additionally, the participants chose a time for their interview convenient for them to mitigate any loss of potential income they may receive as a result of fee-for-service income.

Summary

In this section of the proposal, the research design was discussed and how the qualitative properties of this project aligned with both the purpose of the study and the research questions was illustrated. The interview questions were identified relative to factors found to be useful in in identifying women with ADHD through the ASRS v1.1, especially the inattention component of ADHD. The methodology section identified how data will was collected, participants recruited, and the interview schedule used. The data analysis and ethical procedures were also discussed. In Section 3, the findings of the study will be presented.

Section 3: Presentation of the Findings

The lack of diagnoses of ADHD among girls is troubling because it results in undertreatment, which can have consequences for adult females later in life. In the United States, as many as 60% of all mental health providers are clinical social workers. As such, women whose ADHD has been underdiagnosed and undertreated are likely to seek help from clinical social workers. Within the context that distributive psychological justice for all clients is achieved when clients are given a diagnosis that enables them to access services they need and deserve (Wakefield, 1988), research is needed to show how clinical social workers screen women for ADHD.

The purpose of this qualitative study was to explore how clinical social workers in private practice in a northeast area of the United States screen their female clients for ADHD. This information is necessary to determine whether there might be a problem with screening women for ADHD because there is no research that shows how clinical social workers screen female clients for ADHD. I collected data by conducting semistructured individual interviews with six licensed clinical social workers in private practice in a northeast United States area who were asked to provide information that related to the following research questions:

Question 1. When clinical social workers see adult female clients in their private practice, how do they determine whether a client may have symptoms of ADHD?

Question 2. If a female client has a diagnose that is not ADHD, in what ways do clinical social workers screen for ADHD relative to the diagnosis they already have?

Question 3. If clinical social workers question the possibility of ADHD in female patients/clients, what risk factors, symptoms, and behaviors do they consider in assigning an ADHD diagnosis?

Question 4. What, if any, instrument(s) do clinical social workers use to screen female clients for ADHD?

Question 5. In thinking about how clinical social workers screen adult female clients for ADHD, how do they describe how screening impacts the diagnostic procedure in terms of referring to another professional versus treating the patient themselves?

This next section of the capstone document will address the data analysis techniques and the findings.

Data Analysis Techniques

In this section, I will discuss the time frame for the data collection as well as the recruitment process. Additionally, this section contains results from the thematic analysis using a grounded theory approach of individual interview data. I then provide the findings for the study, which includes the delineation of the process for coding and theme development. A description of the participants is included as well. The section closes with a summary of the findings as related to the practice-focused research questions and a transition to Section 4. In Section 4, I will discuss how the findings apply to the professional practice of clinical social workers and implications for social change.

Time Frame

I collected data were collected during a 6-month period. I sent an invitation to volunteer as a participant in this study via email to a NASW private practice list serve in

a northeast area of the United States, which consists of more than 100 members. Within 1 week of the initial recruitment email, three potential participants expressed interest in receiving an informed consent and the demographic questionnaire. The potential participants then consented to take part in the study. After 1 week, I sent a second initial recruitment email to the listserv due low participant interest. The email yielded three more potential participants, and I repeated the process of obtaining consent. All the participants had consented with the words "I consent" in their response email. Although the goal was to recruit between seven and 12 participants from 75 members of a listserv, only six clinical social workers volunteered to participate in the study. I scheduled and completed the interviews within 3 to 5 business days from the initial email.

Data Analysis Procedures

Five questions, and then additional follow-up questions after each interview, were completed during individual interviews that I audio-recorded, transcribed, and entered into a NVivo software package used to organize qualitative data. I recorded the first interview using the QuickTime application on a MacBook Pro computer. However, the application was faulty and would stop periodically. As a result, there were several stops and restarts during the interview. I converted the recordings from this interview were into a m4a file.

For the remaining interviews, I made digital recordings instead via an external digital recording device and I uploaded them as an mp3 files into the same MacBook Pro computer. I then uploaded the recorded files were into the NVivo transcription service, which transcribed the audio file into text. After the transcription was made, the text was available for edit.

NVivo software enables the user to listen to the audio while editing the text to ensure accuracy in the transcription. Once each participant's transcription was edited for accuracy, the transcription was labeled according to the participant's title as Participant A, B, C, and so on up until Participant F. Each participant's file was uploaded in the data section of NVivo software program under Interviews. Analytic notes from each interview were also uploaded and attached as a "memo" with each participant's transcript in NVivo.

I used a grounded theory approach for the data analysis phase of this study. According to Glaser and Strauss (1967), data should be collected, coded, and then analyzed simultaneously. In doing so, the analytic process for this study involved several steps as detailed in Section 2.

Step 1. Critical reading and rereading the transcribed data to develop a deep connection to the data. Once this was completed, open coding began with each research question, and nodes (as they are called in NVivo) were assigned to these segments of the data from each interview. This process described the first step in analyzing the data.

Step 2. With initial nodes being established from the first interview, axial coding was then employed to break the nodes into specific concepts. Selective coding was then used to extrapolate core concepts from coded data categories. This grounded theory approach was used for the remaining five interviews. Once selective coding was completed, I identified themes.

The use of NVivo coding enables the researcher to see the process of saturation via the aggregation of codes. For example, after coding the first and then second

interviews, each interview (also called *files* in NVivo) would display the number of references each participant made to each code. As subsequent interviews were coded, each reference to the code was shown as a “reference.”

Axial coding was employed once it became apparent that these references pertained to the same codes, and no new codes were being developed. For example, under Question 1, there were 54 references from each of the six participants asking, observing the code “asks about,” “looks/observes for, and “listens for.”

Step 3. After axial coding was completed to identify the relationships between the nodes, and these nodes began to inform concepts within the data (Charmaz, 2006; Corbin & Strauss, 2014). Hence, similar codes were grouped into broader categories. These categories were again arranged by the highest number of references and entered into a NVivo codebook.

The process of initial coding and axial coding was completed after each interview, and in this way, saturation was determined after the completion of the sixth interview. According to Saunders et al. (2014), saturation is met in a grounded theory approach when no new theoretical categories emerge from the data. As such, after preliminary analysis of the data revealed no new nodes, saturation was met. After axial coding was completed, selective coding was used to take the core concepts from the axial codes to form categories to apply to the inductive (data-driven) stage of analysis.

Step 4. The interview guide (see Appendix A) enabled these categories to be identified, which were then used to formulate themes which then answered the research questions.

Validation Procedures

To ensure trustworthiness in qualitative studies, Ggafouri and Ofoghi (2016) suggest validation as a continuous process in data collection. In this study, this included member checking, accuracy checking, assuring dependability via an audit trail, establishing dependability, and confirmability. As member checks are useful for obtaining approval and trust from the participants (Thomas, 2017), member checking was completed after all questions were asked and answered by the researcher, where the participant's responses were read back to the participant. Any discrepancies were corrected at the time of the interview.

Another procedure used for validation was to listen to the audio recording while editing the transcription. This allowed for clarification of words and nuances that proved difficult to hear or understand. Once the transcription editing was complete, each transcription was entered into a word document and sent via email to each corresponding participant to review for accuracy. One participant responded with a few adjustments, mostly to omit qualifying words such as "always," or "never." Another participant replied with "thank you" and no additional information added to the transcript. The third participant expressed concern overusing "the same qualifier." The other three participants did not respond.

Dependability was established in the approval of a panel of experts (i.e., doctoral committee) that the raw data identified in the responses of participants supported the findings in the study and could be identified using an audit trail. The audit trail was established by keeping records of the raw data, the field notes taken during data

collection, member checking after the data was transcribed into text, the transcripts from NVivo, and the notes created in analytic memos during the coding process.

Last, transferability was seen in thick descriptions from the data collected in this study which might be used in future studies. Confirmability was established using the same interview script for each participant to ensure that the outcomes of data collection were the perceptions and experiences of the participants. As such, once both transferability and confirmability were employed, the validation of this study was complete.

Limitations

Inexperience as a qualitative researcher may affected the data collection. For example, a problem with QuickTime stopping repeatedly occurred during the interview with Participant A. On the first occasion, the researcher noticed the recording had stopped during the first question. As a result, the recording had to be rewound to pick up where the interview left off, and the participant restated her answer. This problem happened another time during the interview, and the process of rewinding and repeating the response was repeated. As a result, the researcher was distracted by having to check if the recording was engaged several more times during the interview. Fortunately, the next interview was on the following day, and a new audio recording device was purchased with good results for the subsequent interviews.

Another limitation was the number of questions asked which lead similarity in answers especially between questions one and three. As a result, I felt rushed to complete the interviews in the time frame allotted and as a result, I was not able to ask more

probing questions which might have resulted in more rich text. Additionally, I might have given each participant a copy of the interview questions to follow along which might have given the participants time to peruse all of the questions before the interview began.

Findings

Prior to presenting the findings, the sample will be discussed. The participants for this study have been licensed clinical social workers from 7 to 38 years, and all have practiced clinical social work in a Northeastern area of the United States for the entirety of their careers. The age range of the participants was from 32 to 74 years of age. Of the six participants, five identified as female and one identified as male. All the participants were in private practice. One participant had recently started in private practice and still held a full-time position at a local outpatient mental health clinic. The participants practiced within a 50-mile radius of this author. Table 1 illustrates the demographic profiles of the six participants in the study.

Table 1

Participants by Characteristic (N = 6)

Characteristic	Frequency
Gender	
Female	5
Male	1
Age	
25 - 44 years	1
45 – 54 years	2
55 years and older	3
Years of experience	
Less than 15	1
15 – 25	2
More than 25	3
Annual assessments	
20 or less	2
More than 20	4

Participant A

The researcher met Participant A at her office located in a commercial office building located in a marginalized inner-city environment with a lower-income population, and higher drug use and crime rates. Her client population includes seeing a higher population of clients with a history of drug use and abuse. After passing out cookies to her receptionist, she greeted me with a warm welcome and began to discuss her office space. After offering choices such as a conference room or her private therapy office, we agreed her office would offer the privacy promised in initial recruitment. Her

office was warm and inviting with two wing chairs, a desk, a book self with clinical social work reference books, and a side table with a coffee machine, orange juice, donuts, and other snacks.

Participant A sat at her desk and I sat in a wing chair facing her. I got the sense that Participant A cared deeply for her clients and wanted them to feel as comfortable as possible during their therapy sessions by being well nourished and sitting in a comfortable chair. She was well-prepared for our interview having printed out her own 10-page diagnostic assessment form, several screening instruments to include the *Mood Disorder Questionnaire* (MDQ, Hirschfeld et al., 2000), and the *Brief Psychiatric Rating Scale* (BPRS, Overall & Gorham, 2016)). One hour was spent answering the interview questions and the other hour (not recorded) was spent talking about her history as a clinical social worker and some of the changes to the practice of social work over the years to include the several revisions of the DSM.

Participant B

During initial recruitment, Participant B expressed some concerns about her privacy. She wanted assurance that her data would remain private and had asked for more detail about how her information would be recorded and then saved. She also confided prior to her interview that she was diagnosed with ADHD-Inattentive and wondered if this information would be relevant for me to know. Participant B chose to meet at her home in the morning. Upon entering, she immediately apologized for “her messy house” because she and her family had just entertained the night before.

She offered me a place at her dining room table and a glass of water, and we began with some small talk about her family and her home. I got the sense that Participant B was well-read about ADHD and was able to reference several books specializing in the treatment of ADHD to include one recent book about women with ADHD. Her office is located in a medium-sized diversified city with lower crime rates. The interview lasted one hour.

Participant C

I met Participant C at her private office within a collaborative of other clinical social workers in a prestigious section of a large city known for high-income, highly educated, and a less diversified population. She greeted me in her waiting room after offering me a cup of coffee and led me to her office. Her office was cozy, tidy and modern with a comfortable chair and couch. She was confident and open with her answers offering rich data about her clientele, which she shared were primarily female and younger as she was located in an office close to several colleges and universities. I got the sense that Participant C knew her clients well and was able to establish rapport with them readily with her no-nonsense approach appropriate for a clinician with 28 years of clinical social work experience. Our interview lasted one-hour.

Participant D

I met Participant D at her home. She led me into her living room and was eager to make sure I was comfortable. She had several friendly cats who paraded around us expressing curiosity over the process by walking over the recording device, my notepad, and across my shoulders. You can hear our giggles in the interview and in some places,

the soft purring from one of the three cats. Part of Participant D's private practice entails work with a local prestigious university as part of their employee assistance program. She revealed that she became especially interested in ADHD after her spouse was diagnosed with ADHD five years ago when both her husband and young child underwent extensive testing completed by a neuro-psychologist.

Participant E

Participant E responded to my second recruitment email. We met at his office in a small suburban town where he shares the space with another clinical social worker. Participant E met me in his waiting room with a friendly greeting. After challenges in situating myself on a large comfortable couch where I sank into the point that my feet could not touch the floor, I got the sense that Participant E found humor in my process to get organized. His humor and his relaxed, confident manner remained throughout our interview. Participant E revealed that approximately 70% of his caseload was male and that over the years, his practice has almost defaulted to working primarily with older adolescents and young adults who have ADHD which he considers his sub-specialty.

Participant F

Participant F agreed to meet me at her home. She had just received some uplifting news and was on the phone sharing with her spouse this news when I arrived. She appeared excited and shared with me her discovery. I was surprised that she kept our scheduled interview, but she remained committed to the interview. Although Participant F was understandably distracted throughout our interview, she delivered her responses easily. It became clear to me that her seven years as a clinical social worker working in a

satellite clinic of a renowned hospital screening clients after a first psychotic episode rendered her well-versed in the screening process for mental health issues.

Research Questions

In describing the participants, it became clear that they all have unique settings and serve a variety of clients. They were all generous in sharing information about their practice with ADHD. In this section, that information will be shared relative to the research questions posed to them.

Research Question 1: When clinical social workers see adult female clients in their private practice, how do they determine whether a client may have symptoms of ADHD?

During the interviews, the descriptions on how the participants determined whether or not their female clients may have symptoms of ADHD included an interweaving of them asking about, observing/looking for symptoms, and listening for symptoms that might suggest the need for a diagnosis. Most of the participants described they will use their knowledge of ADHD symptoms when and if they begin to hear symptoms, they will entertain whether or not they will use a screening instrument for ADHD.

When conducting initial coding 55 references were made to the node of Asking, 29 references were made to the node of Observing and Looking, and eight nodes referencing the node Listening were developed. Hence, all participants will rely their knowledge of ADHD and do so by then asking questions, listening and observing for symptoms. When using the word frequency feature in NVivo for asking, looking and

observing, and listening for symptoms, these categories then informed the three themes, 1). Asking questions about symptoms, 2). Observing and looking for symptoms and 3). Listening for symptoms. Hence, the themes that emerged were best suited to answer how clinical social workers determine whether or not their client may have symptoms of ADHD. Selective coding involved deleting those nodes least relevant to this (and subsequent) questions.

Asking Questions About Symptoms

The participants demonstrated that asking questions is an essential component of the clinical assessment by the number of references to asking questions. All six of the clinical social workers relied on primarily asking questions to ascertain challenges in executive functioning commonly found in ADHD. Their knowledge about tenets of executive functioning included; organization, working memory, and planning symptoms.

For example, Participant A was confident in her ability to ask questions from several screening instruments she asks her clients to complete before their initial assessment by “making little checkmarks in the screener where those symptoms may come up” and then begins asking questions specific to ADHD presentations. However, she acknowledged that she does not use a specific screening instrument for ADHD and questioned if “there was one available.” To prove her point that she does screen, albeit without an ADHD screening instrument, she showed the checkmarks she had made in her assessment and screening packets to discern possible symptoms of ADHD.

Participant E reported having a sub-specialty in working with clients who have ADHD. Although he admitted 70% of his caseload being male, he found that the majority

of females who have come for another disorder were actually screened for ADHD and then re-diagnosed with ADHD. As a result, Participant E feels more comfortable relying on asking questions directly from the DSM 5 about symptoms associated with ADHD to assure he has met the guidelines. In his many years of practice, Participant E humbly revealed he has been incorrect in his diagnosis only once when he mistook bi-polar symptoms for the hyperactive/impulsive component ADHD.

Participant F stated, “I think a lot about questions associated with executive functioning, so I am thinking about memory, forgetfulness, organizational skills. You know, focus, concentration when talking. And also, how long has this been going on? She then relies “asking if there are any impairments in these areas.”

Observing for Symptoms

Two of the participants relied on their observational skills for ADHD symptoms. Participant E exclaimed,

> It's primarily observation, observation particularly of the interaction of style. Certainly, observation of motorist activity, but probably less so than just observation of how she presents, and you know, kind of speed at which she speaks. This is an overall manner, how organized or disorganized she might be in her thought process. That’s the thing that when I observe that, then that’s when I might go more deeply into the whole ADHD question.

Participant A reports relying on observations as well as her screening and assessment and checklists by stating that she has written a paper on the topic of ADHD and is now “very aware of the symptoms.”

Listening for Symptoms

Listening is a technique the clinical social workers used to help ascertain deeper meaning. The participants used two kinds of listening skills, active listening and empathic listening.

Active Listening. Active listening enabled the clinical social worker's ability to paraphrase their client's symptoms, especially as they might relate to ADHD symptoms. Participant C relies on active listening as well.

> The first thing I do is if I hear any of the symptoms that are listed in the DSM 5, I will start asking them questions, basically going down the list of criteria in the DSM 5 to find out if they're experiencing any of those symptoms.

Participant F relies first on active listening as well and uses this skill to begin to think about formulating questions.

> So, thinking about memory, forgetfulness, organizational skills. You know, focus, concentration when talking. And also, how long has this been going on? So, if there's any impairments in these areas, has it been throughout lifetime? Has it impacted any school, any work or, you know, day to day stuff? Can you never find your keys in the morning? Right. You know, things like things like that. Is it new? So, to help determine normalcy when they come to us, we know that there is something happening. Whether it's depression or anxiety, psychosis, whatever it is. And so really getting the sense of what has always been the case or so is it a new part of their history. And so, you know, is it a result of depression or anxiety or has it been a lifelong challenge? Have they ever been on any IEP at school, any, you

> know, ever needed accommodations or any diagnosis in the past? And also, like any struggles in school, getting things done on time, completing things, things like that.

Empathic Listening. Empathic listening enabled the participants to be in the moment with their client. Participant D allows the client to speak of their experiences so she can experience her clients on multiple levels. For example, she recalls her spouse's struggles such as troubles in academic settings and subsequent feelings of failure prior to his diagnosis of ADHD. Hence, she is careful not jump ahead with screening. "Although I'm not asking a pointed question to screen for it, I'm listening for signs or symptoms. If there's anything that sounds like it could be related to ADHD, I might float the idea." Participant F thinks about the long-term effects associated with multiple symptoms associated with ADHD as she listens to her clients. In her case, she listens for symptoms associated with everyday activities, such as clients who are constantly losing keys, and past issues that may have occurred in academic settings. It is evident that both participants listen intently for past and present signs and symptoms as their clients tell their stories. The results in Table 2 show how the most frequent themes in understanding how clinical social workers screen their female clients for ADHD.

Table 2

Frequency of Themes in Participant Responses about How to Screen Female Clients for ADHD

Theme	Frequency
Asking about	
Executive functioning	6
Drug use	11
Symptoms associated with mood	3
Observing/looking for	
Hyperactivity	3
Inattentiveness	18
Impulsivity	1
Listening	
Actively listens and paraphrases symptoms	5
Empathically thinks about effects of symptoms	2

Research Question 2. If a female client has a diagnose that is not ADHD, in what ways do clinical social workers screen for ADHD relative to the diagnosis they already have?

In screening clients relative to a DSM diagnosis they may already have, there were several ways the participants screened for ADHD. A total of 24 initial nodes were referenced from open coding of the data. Axial coding revealed categories of diagnosed

comorbidities commonly found in women with ADHD such as major depressive disorder, general anxiety disorder, bi-polar disorder, substance use disorder, oppositional defiance disorder, PTSD, Autism Spectrum, and feeding disorders such a binge-eating disorder as ways the participants think about screening for ADHD. Several participants acknowledged that not all of their clients come in with a previous diagnosis. As such, clients who come in with symptoms specific to executive functioning challenges, especially as these skills related to work, school, and everyday life, alcohol and substance use and abuse, symptoms of anxiety, and symptoms of depression which are indicative of comorbidities are also ways the participants think about possible comorbidities. Selective coding involved removing irrelevant codes that did not reference the themes stated above.

Mood Disorders

Participant B has had a lot of personal experience in her life with ADHD and is knowledgeable about mood comorbidities for women with ADHD. In the following quotation, she noted important questions to ask in screening women for ADHD in the following quotation.

> When a client presents with symptoms of depression, as part of screening for challenges with daily functioning, I will ask how they are doing at work, how they are doing in their management of daily life, how they are sleeping? I know that depression and ADHD go hand-in-hand and anxiety.

Participant B also reported that the majority of her female clients do not come in with a diagnosis of ADHD, but that she's "making room for the possibility that they may have some difficulty with feelings of depression, whether it meets the criteria for

diagnosis or whether a diagnosis could be there. We know that ADHD is very under-diagnosed for women." Participant C agrees that many of her clients do not come in with a diagnosis of ADHD, but rather come in "With a lot on anxiety, so sort of a crisis."

Participant F thought about previous diagnosis of depression treated with anti-depressant medication but who still experienced reoccurring symptoms. In this case, she thought about ways symptoms such as "feeling foggy" and having "trouble thinking clearly" relate to inattentiveness in ADHD and will screen accordingly. On the other hand, Participant D knows that many of her clients come in with a previous diagnosis of depression or anxiety but does not usually think about how it might correlate with ADHD unless she begins to hear more about other symptoms associated with ADHD. Participant C and F think about clients who experienced symptoms of stress, anxiety and depression as a result of repeated failures in both academic and work settings as a way to screen for ADHD in their female clients.

Bi-Polar Disorder

Bi-polar disorder as a comorbidity was mentioned by Participant A who had produced the Mood Disorder Questionnaire (MDS) at the beginning of our interview. She stated she "often uses a screening instrument especially during my intake sessions if I noticed a high level of activity during the interview," and then pointed to her MDS screening instrument while further stating "to help me differentiate between the two."

Substance Use and Substance Use Disorder

Participant A thought mostly about stimulant use as a way to screen for ADHD. Whether she acknowledged stimulant use in her screening instruments or in her

diagnostic assessment form, she reported that as a clinical social worker who works mostly with an inner-city population, she inevitably sees “many female clients with a history of drug use and abuse, especially cocaine.” When discussing drug use, Participant A stated that, “I often check off cocaine. That’s the key problem. It really is. Sometimes they can try it once and they’re fine or sometimes after one time, because of their genetics, they’re hooked. That’s a huge danger.” Participant C agrees with stimulants, especially cocaine, as problematic drug use in her clientele. She describes how many of her clients “have tried stimulants to see what their reactions might be. Whether it is to help them concentrate or to calm down, I use my clients’ physical responses to stimulants as a way to determine screening for ADHD.”

Executive Functioning

Some of the participants reflected solely of executive function challenges and others on how academic difficulties correlated with executive function challenges and disruptive behaviors in school that lead to thinking about an ADHD diagnosis for their female clients. Participant F considered a history of challenges for her clients.” So, thinking about memory, forgetfulness, organizational skills, focus, concentration when talking I think about symptoms such as those in school, daily life functioning.” She pauses for a moment, thinking about a client’s history of executive function challenges and adds, “How long has it been going on?” After another pause she concludes, “When I am thinking about ADHD, then I ask if they have ever been on an IEP, had struggles at school, getting things done on time.”

Participant B agrees in that she thinks about her client's "history of any challenges at school or work related to executive functioning" while Participant F thinks specifically about "executive functions related to thought process as a key indicators." Participant F also "thinks about a history of academic difficulties and having disruptive behaviors at school."

PTSD/ODD/Feeding and Eating Disorders

Although there was only one reference to each of the following disorders, they are relevant comorbidities to add as the participants acknowledged they are often found in clients with ADHD. For example, Participant F stated, "I think about PTSD and how clients present with hyperarousal, vigilance, and struggles with concentration and focus as symptoms." She then added, "I know it can be present in both PTSD and ADHD or having an adjustment disorder diagnosis."

Participant E reported that some of his clients "have a history of troublesome behaviors," and after pause, thought more about "highly disruptive and troublesome behaviors" that could be an indicator for Oppositional Defiance Disorder "which would then lead to screening for ADHD." Participant B stated that she often "thinks about her clients who have a history of feeding disorders as a way to further screen for ADHD," when she was listing comorbidities.

Autism Spectrum

Three out of the six participants state their female clients often expressed concerns with being on the autism spectrum due to emotional dysregulation and challenges with making friends.

Participant D will rule out being on the autism spectrum in her female clients.

"I've started hearing women casually mentioning concerns over Asperger's because of their concerns with socially awkward behaviors such as impulsivity and moods that can also be related to ADHD."

Participants A and F reported that clients may have been diagnosed as a child with being on the Autism spectrum but have been later diagnosed with having ADHD because the presentation of more mild symptoms of emotional dysregulation and impulsivity which can present similarly. The findings in Table 3 reflect the thematic analysis of responses to Question 2.

Table 3

C-morbid Disorder and Symptom/Behavior by Frequency

Comorbid disorder and symptom/behavior	n	Frequency
Neurocognition	16	
Inattention		6
Cognitive differences		3
Disorganization		2
Impulsivity		2
Other		3
Mood Disorder	9	
Anxiety		4

(table continues on next page)

Depression		3
Stress		2
Substance use/misuse	6	
Substance(s)		4
Alcohol		2
Neurodevelopmental	5	
Awkward in social relationships		2
Emotional dysregulation		2
Isolation		1
Post-traumatic stress disorder	4	
Anxiety		2
Focusing		1
Traumatizing events		1
Oppositional defiance disorder	3	
Trouble with authority		2
Disruptive behaviors		1
Eating	2	
Binging		1
Purging		1
Bipolar Disorder (highs)	1	1

Note. Neurocognitive "other" category includes hyperactivity (1), focusing, (1), and concentration (2).

Research Question 3. If clinical social workers question the possibility of ADHD in female patients/clients, what risk factors, symptoms, and behaviors do they consider in assigning an ADHD diagnosis?

The clinical social workers in this project were well aware of the challenges their female clients experienced as well as some of the outcomes that might have resulted from being underdiagnosed and undertreated for ADHD. All participants responded readily, and 24 references were made to the categories of inattentiveness, hyperactivity, and risk factors most commonly found in the DSM 5 for ADHD criteria.

Behaviors Related to Inattentiveness

Inattentive symptoms were noted to be the most prevalent in female clients and having 13 out of 25 references made to inattentiveness is illustrative of this phenomenon. Inattentiveness spans across occupational, educational, and social settings, however, the most widely referenced areas in this study pertained to school and work. Several of the participants described how their female clients experience inattentiveness. Participant B is particularly familiar with the inattentive component of ADHD as she reports she and "two of her children as well as the majority of her siblings have been diagnosed." For example, "If the word distraction comes up such as not being able to manage productivity or feeling as though they have to work a lot more than their peers," then she considers this symptomatic for inattentiveness. Participant C agrees that inattentiveness is a major consideration and describes her clients' experiences in academic and work settings.

> They got through school but had to work really hard at it. They are doing fine at work, but they have to work really hard at it. And it takes them way more time to

> get the job done than their co-workers or they are spending way more time at work thein the majority of their coworkers. One of the sources of shame is all the messages they receive around these difficulties such as they are lazy, they are not working hard enough, if they just applied themselves regardless of how hard they are studying or working. Zero positive outcome.

Behaviors Related Hyperactivity/Impulsivity

Behaviors around impulsivity such as initial stimulant use and abuse were of concern, especially those clients who were later screened and shown to have ADHD symptoms. Participant C stated her clients "use stimulants such as cocaine to combat hyperactivity and to mitigate inattentiveness" and in some cases have treated clients who "have become addicted to substances such as cocaine to "help them feel normal, to help them focus, and get stuff done which is something they reported they were not able to do off cocaine."

Participant A was deeply troubled by her client's use of cocaine and described two instances of where clients who have already been diagnosed with ADHD, but who were not medicated. She described a client who came in describing cocaine addiction for herself and her child with ADHD as a result for trying to find relief for the hyperactive and inattentive components of ADHD.

> Sometimes they'll try to self-medicate. Later on, they would start street drugs. The fastest thing they might bump into is cocaine. So, they tried cocaine and they'll come down instead of getting roped up. And they like that. They could try it once, maybe they didn't like it and they'll never tried again. So, it is a huge

> danger. And I see a woman who has ADD. Her son does, too. She's a nurse. She didn't want him medicated for ADHD. He turned to street drugs and he later died of an overdose.

Participant C agrees with impulsivity around drug use and describes clients looking for "cocaine, amphetamines, crystal, Ritalin, Adderall, you know, the stuff they get from friends or off the streets to see what their reactions are to that stuff."

Participants C and D reported high usage of caffeine which was an indication for them that perhaps these clients fared better in both attentiveness and productivity in academic and occupational settings. Three clinicians reported high instances of marijuana use in their clients. For these clients, Participant B reported concern over high marijuana usage to help "deal with symptoms of anxiety, especially in areas of low productivity at work due to inattention."

Risk Factors Considered

There were four references to risk factors from five of the participants. All of these participants reported they consider a family history of ADHD to be a risk factor for women. Participant B considered a "family history of a comorbid depression, anxiety, or alcohol and substance abuse could possibly mean a family member might have an undiagnosed ADHD." Participant C acknowledged "Since my husband has ADHD, I understand now my son, and possibly my daughter has the diagnosis."

Research Question 4. What, if any, instrument(s) do clinical social workers use to screen female clients for ADHD?

None of the participants acknowledged using a tangible screening instrument specifically used to screen ADHD. However, there were 31 references made to either "thinking about" or "using diagnostic criteria" as a screening instrument. Two participants expressed they "pointed to" ADHD screeners and one stated "I don't administer it myself," but that she will later refer back to the reading she has recommended on ADHD to "see if it is a thing." After axial coding, five categories emerged, the *DSM-5,* the *DSM-4*, and the *The World Health Organization Adult ADHD Self-Report Scale (ASRS v1.1,* Kessler, Adler, Demler, et al., 2005), and a general screening instrument, such as the *Perceived Stress Questionnaire* (PSQ, Fliege et al., 2005), which includes questions which might warrant further screening into specific symptoms associated with ADHD such troubles with concentration, troubles relaxing, or having little energy.

DSM-4 and DSM-5

Both the *DSM-4* and the *DSM-5* were the most common references as both a screening instrument and a diagnostic instrument by three of the participants. Participant C states that she "does not have actual tools other than the checklist to the DSM," and then described how she used the DSM-5 as a screening instrument when she first starts hearing symptoms which might be indicative of ADHD. "I will start asking them questions, basically going down the list of criteria in the DSM-5 to find out if they are experiencing any of those symptoms." Participant E, who has been a clinical social

worker for many years and stated he has a sub-specialty in ADHD stated, “At this point in my career with the work I have done, whether or not somebody has ADHD something that occurs to me rather quickly.” Participant E cites the categories and numbers of symptoms for ADHD in the DSM-5 and then describes how he discusses with his female clients as a screening measure prior to then through the DSM-5 list of criteria with his clients. Participant F stated with confidence that she uses her “brain and the DSM. Although, to be fair, I was trained on the DSM-4.”

PSQ

Participant A uses the PSQ during her intake session with her clients. She reports, “I use that to give me a bigger picture. It is not specific to ADHD.” Later, Participant B describes, “I do have a screening instrument that I use specifically for women, but I cannot recall the name.”

ASRS

Participant D does not use a formal screening instrument in her intake sessions but stated she “will point clients to the World Health Organization Adult ADHD questionnaire (ASRS) and I will suggest the Hallowell and Barkley's Web sites to read a little about it. See if it is a thing.”

Some participants also recommend the of use books, but in conjunction with an ADHD screening instrument they have recommended to their clients. Over subsequent therapy sessions they will use the client’s new knowledge to help relate their experiences with ADHD symptoms. For example, Participant C stated, “The other tool that I use is the book *Driven to Distraction* by Hallowell to see if they are interested in wanting to

figure this out" in their subsequent sessions with her. Participant F uses "a handout written by Hallowell on symptoms of ADHD and on executive function dysfunction," and further recommends "they do their own research (on ADHD) to talk about in subsequent sessions." These participants further reported that once their client has read the recommended material, they will also review the symptoms with their clients as the process they use to screen for ADHD.

Research Question 5. In thinking about how clinical social workers screen adult female clients for ADHD, how do they describe how screening impacts the diagnostic procedure in terms of referring to another professional versus treating the patient themselves?

There were 25 references to how screening impacts the decision of participants to make an ADHD diagnosis as part of diagnostic procedure and then, how this diagnostic procedure impacts their decision to refer their client to another professional. Two categories emerged from these references; making diagnostic decisions and referring clients out. When making diagnostic decisions, several subthemes emerged: lack of qualification and protecting clients**.** Additionally, **s**everal subthemes emerged from making referrals, including referring out for a medication evaluation and referring out for school/work accommodations. The last category was diagnosing and treating.

Lack of Qualification

Two participants reported feeling uncomfortable with diagnosing ADHD because they feel unqualified to do so. Despite attending one-day workshops to help her with the instruments used in screening for ADHD, Participant B felt she "had not gotten to that

level where she felt comfortable in diagnosing." Additionally, Participant B was passionate in stating she did not think clinical social workers were "even qualified" to diagnose their female clients with ADHD.

> Unless you are doing pretty rigorous testing it and I'm not trained in that. I'm not a trained psychologist. I don't do bias. I don't do neurological testing. I have attended various trainings over the years and my understanding, which may be false, is that you have to go through rigorous testing or sometimes brain scans. There really is no way to confirm. Unless you are doing pretty rigorous testing it cannot be confirmed, and I'm not trained in that. I'm not a trained psychologist. I don't do bias. I don't do neurological testing.

Participant C also reported a lack of qualification in diagnosing her female clients for ADHD after screening. She argued:

> So, in terms of diagnosing, I rarely write ADHD as a first diagnosis and less they are coming in telling me they have it because I feel like I am not qualified to definitely say this is ADHD. You know, I think that neuropsych testing is absolutely necessary for that as well as seeing a psychiatrist. Social workers don't have the specialized training. I don't ever say you definitely have ADHD. I just feel like I'm not qualified to do that. I don't think I would even write rule out. I don't think I would just write anything in the record.

Protecting Clients

Participant B expressed concern around the implications of an ADHD diagnosis when she stated, "I'm more cautious around diagnosing. I guess its's because it's public

information. Unfortunately, when people submit this, as much as we want to believe that the insurance companies keep it private, there’s always medical records sharing.” After a thoughtful pause, she added she “will give them an informal diagnosis but will not put it in their record out of fear that if it is on their record, it may impact their life insurance policy.”

Participant D expressed concerns about her clients’ comfort level with an ADHD diagnosis. For example, she reported that although she “feels comfortable diagnosing somebody, I probably see more resistance from the client in accepting that diagnosis.”

Conversely, Participant C exclaimed:

> My clients fear that they'll find out it's inconclusive or that they will find out they don’t have ADHD. This means that they must do the work, and it really means that they are defective because they don't have the diagnosis. It’s the profound shame they feel in seeing themselves as defective.

There were 13 references to how screening impacts the diagnostic procedure in terms of referring to another professional versus treating the patient themselves. Seven references were specific to referring a client out if medication to treat the symptoms of ADHD were desired and some are illustrated in quotations.

Referring Out for Medication Evaluation

Participant A states she will refer out “If I think a client might benefit from any type of medication, I have a doctor that I use.” Participant C agrees and states, “I will put it out there, you know, you can meet with a psychiatrist if you want to explore a medication route.” There was one reference for referral to a psychiatrist to see if taking

medications for ADHD might mitigate symptoms, hence proving an ADHD diagnosis is valid. Participant B stated, “They could see a psychiatrist to see if there is a medication that could further help us tease that out.” Participant C suggested, “going to a psychiatrist or a psychopharmacologist if they want to formalize the diagnosis and if they want to consider taking medication.” She also added, “I would say you could just go to a psychiatrist and they’ll do their evaluation.”

Referring Out for School/Work Accommodations

Two references were made making a referral if academic accommodations were needed or if they needed a diagnosis documented. For example, Participant B stated she would refer out to a neuropsychologist, “If they needed to nail that diagnosis down and get any kind of accommodations at work or in their academic settings or whatever they feel would be helpful.” Participant C agrees and expresses concern that many of her clients with ADHD work in an open-concept office space with little structure. She stated, “It makes it a little bit easier for what accommodations they might need at work.”

Diagnoses and Treatment

One last reference was made to describe how screening impacts the diagnostic procedure in terms of referring to another professional as well as treating the patient themselves. Participant F exclaimed that,

> I've never referred somebody out for anything because I didn't feel comfortable. I just keep trying. I mean, I've always thought that if we're hanging out a shingle, and we're in private practice, it's our obligation. If there's something we don't feel

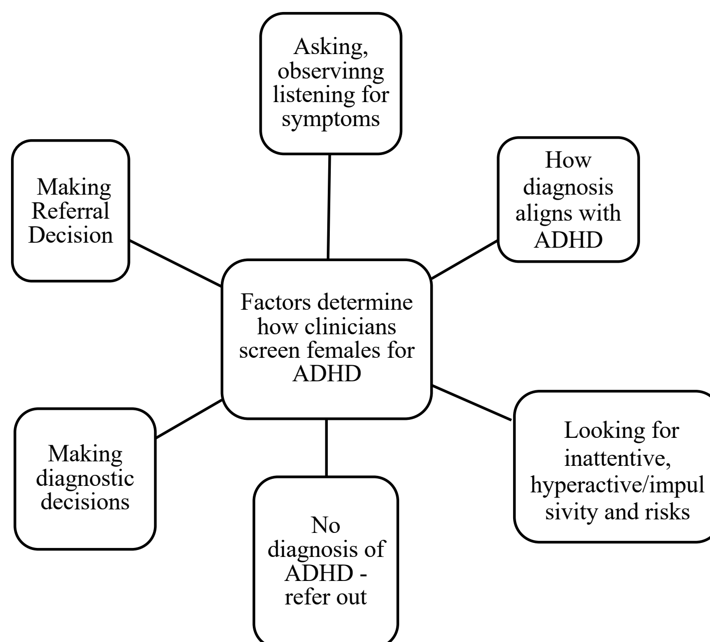
we don't know, we ought to learn about it, and then we ought to do our best to figure it out and then learn about whatever the condition is from the client, too.

Summary

Section 3 presented the findings for the study. The findings provided insight into how clinical social workers make decisions to screen female clients for ADHD. Figure 1 illustrates the findings in the factors clinical social workers use to determine screening for ADHD in their female clients. Figure 1 represents hoe clinical social workers screen their female clients for ADHD.

Figure 1.

How Clinical Social Workers Screen Their Female Clients for ADHD.



These insights are relevant to recommendations presented in Section 4 to enhance clinical social work practice screening methods for women whose presentations of ADHD might be underdiagnosed.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this qualitative study was to explore how clinical social workers screen women for ADHD. Within the context that many women may be underdiagnosed with ADHD, this information is necessary to determine which women may need to be diagnosed with ADHD and properly treated. I conducted the study because there was little evidence in the literature to show how clinical social workers screen female clients for ADHD. The participants in the study were clinical social workers in private practice in a northeast area of the United States.

Key Findings in the Study

In response to questions posed to the clinical social workers who participated in the semistructured individual interview, key findings can be summarized from identifying themes from the research questions. First, the data revealed a reliance on heuristic knowledge of ADHD, which seems consistent with previous findings that show females are not being screened for ADHD in mental health centers (Corbisiero et al, 2017; Quinn & Madhoo, 2014). Clinical social workers use asking, looking/observing, and listening, especially active and empathic listening skills evident in participants' responses, to then discern risk factors and areas needing further exploration. Most use no screening instruments and, in the absence of doing so, they are unable to identify signs and symptoms associated with ADHD that have been present through time but have not been formally diagnosed and thus are missed. Instead, they rely primarily on their client's responses of stimulant usage and inconsistent signs and symptoms of inattentiveness to informally screen their female clients for ADHD. However, stimulant usage is not listed

in screening instruments for ADHD and inattentive symptoms are delineated across 9:18 of the ASRS-v1.1 symptom checklist.

Second, clinical social workers use diagnostic criteria for screening as opposed to using an ADHD-specific screening instruments, which is a new finding from this study. The participants identified an informal systematic screening method using the client's previous diagnosis to then think about how they might align with presentations of ADHD. These presentations were identified by using the information gathered from female clients and then using either the diagnostic criteria from the *DSM-4* and *DSM-5*, or using the PSQ, or pointing to the ASRS to determine areas needing further exploration. As a result, clinical social workers appear to skip screening and default to diagnostic criteria which was not identified in the literature.

Third, clinical social workers were able to identify key comorbidities found in women that then lead them to consider using a screening instrument for ADHD, which indicated that many of the participants in the study were familiar with the common comorbidities found in women with ADHD, including mood disorders, bipolar illness, feeding disorders, and ODD, which is consistent with previous studies (Fuller-Thomson et al., 2016). So when these diagnosis were presented, the participants considered screening for ADHD, and they looked (as opposed to asked) for behaviors related to primarily inattentiveness which is most commonly found in women with ADHD (Quinn & Madhoo, 2014). Unfortunately, looking and observing for these behaviors does not qualify in the same way that asking specific questions from an ADHD screening instrument qualifies.

The fourth finding was that only one clinical social work identified the hyperactive component of ADHD as a risk factor, which is consistent with the findings in one study (Fuller-Thomson et al., 2016) and therefore do not ask, look/observe, or listen for those signs and symptoms. The absence of asking questions specific to ADHD presentations indicates a possible use of bias in identifying in women. Quinn and Madhoo (2014) identified that although boys present more often with hyperactivity than girls, which may render their symptoms more easily identifiable, hyperactivity is still present in girls. However, Quinn and Madhoo further posited that despite identifiable hyperactive symptoms in girls, bias informs treatment referral and is especially evident in the participant responses. For example, only one of six participants asked about hyperactivity in their female clients which would enable further exploration of the eight criteria for hyperactivity and impulsivity.

The last finding revealed that most clinical social workers do not screen female clients for ADHD with the intent to diagnose those clients with ADHD. Based on responses of participants in this study, it seems that although clinical social workers are licensed to assess clients for ADHD in their female clients, which includes using ADHD screening instruments to discern signs and symptoms needed for further exploration to then diagnose ADHD in their female clients, most do not assess their female clients for ADHD. Instead, they use primarily diagnostic criteria to then only validate their client’s symptomology, though one participant used the diagnostic criteria to then diagnose for ADHD.

Among clinical social workers, the problem that women with ADHD are underdiagnosed might not be due to a lack of knowledge of ADHD as evidenced by the participant's identification of most of the signs and symptoms especially evident in women, comorbidities, and risk factors. Instead, the underdiagnosis of women with ADHD might be due to the lack of evidence being collected during the assessment process, which includes the use of an ADHD screening instrument to then further explore signs and symptoms of ADHD through time. If the assessment protocol was followed correctly, perhaps clinical social workers would then feel confident in their ability to diagnose their female clients with ADHD.

New Knowledge for the Clinical Social Work Specialty

Taken together, the findings in this study show that clinical social workers in private practice do not formally screen female clients for ADHD using a reliable and valid screening instrument, such as the ASRS-v1.1, which would then lead to a possible ADHD diagnosis. Prior to this study, little attention was given in the literature given to how clinical social workers screen female clients for ADHD. Although clinical social workers have the education and training to diagnose ADHD in female clients, Hamed, Kaur, and Steven (2015) noted that comprehensive research on specific barriers to complete client assessments, which would include the use of screening instruments, may help improve diagnostic rates and treatment of ADHD for all populations.

However, the findings in this current project do introduce strategies that clinical social workers use to informally screen female clients for ADHD. The findings also highlight new knowledge to explain how and why women are underdiagnosed for

ADHD. Wakefield (1988) endorsed distributive justice for all clients when they receive the diagnoses they deserve in order to receive the services they need. When ADHD among adult female clients is undiagnosed and untreated in the clinical mental health setting, it is socially unjust relative to the negative outcomes experienced by women with ADHD (Wakefield, 1988).

Possible Solution

Understanding the gap between screening and then diagnosing is essential to improving the long-term outcomes for women with ADHD and one possible solution to improving the screening process would be to encourage clinical social workers to use two standardized instruments for screening, such as the ASRS- v1.1, which screens for 18 ADHD signs and symptoms currently present, as well as the Wender Utah Rating Scale (WURS, Brevik et al., 2020). The WURS was developed to help screen for signs and symptoms of ADHD present in childhood and continue to be present in adulthood, which is one of the criteria for assigning an ADHD diagnosis (American Psychiatric Association, 2013).

Hence, using both screening instruments would allow clinicians clear direction about how to use screening to further assess problematic signs and symptoms to then decide whether a diagnosis of ADHD seems warranted (Brevik et al., 2020). In turn, this would provide clinicians with the opportunity to assign a diagnosis themselves or refer the patient to another professional for academic and occupational accommodations as well as for medication, if warranted. In the next section, I address the ethical issues that emerged in the findings.

Application for Professional Ethics in Social Work Practice

The participants in this study belonged to an NASW private practice group in the northeast Unites States and, as such, actively consider both ethics and values in clinical social work practice. Yet, there seems to be a conflict with ethics when clinical social workers do not screen their female clients for ADHD.

One conflict centers around professional competence. The NASW Code of Ethics, (2017), Standard 1.04, notes that social workers have a duty to care for their clients and should not diagnose clients without proper training, knowledge, skills, and proper clinical licensure. As clinical social workers are obligated to stay abreast of mental health diagnosis and treatment as part of biannual clinical licensure, they also find that the training they received for ADHD focuses more on signs and symptoms and less on the process of screening, which is paramount in an assessment to then determine whether or not diagnosing their female clients for ADHS is warranted.

Another conflict embodies the client's right for self-determination (NASW, 2017). Standard 1.02 directs clinical social workers to be aware that screening for ADHD might lead to diagnosis of ADHD might subject their clients to risks such as life and health insurance denial, as well as employability if a diagnosis is documented for the clinician's health insurance fee remittance. As such, in cases where screening leads to further exploration of possible ADHD signs and symptoms, the client has the right to accept or reject ADHD the further steps needed for diagnosis.

Recommendations for Improving Screening

The findings from this study have implications for ways that clinical social workers screen to consider whether or not an ADHD diagnosis seems warranted for their female clients. The findings show the need for clinical social workers to screen female clients for ADHD in order to make a decision about using criteria to diagnose or not. The problem seems to be that clinical social workers use the screening instrument to then think about an ADHD diagnosis, and then refer the client out for a diagnosis if the client expresses an interest. With this in mind, the following recommendations seem important.

Recommendation 1

A policy seems warranted to mandate that a reliable and valid screening instrument for ADHD be used during an initial assessment of a female client to determine the core symptoms of adult ADHD. Once these core symptoms are identified, questions that follow will identify the history of these problems that have affected the client's daily life over time.

Recommendation 2

Through advanced clinical training, clinical social workers will be educated as to how to use a proper screening instrument for ADHD and then how the insights gained from screening their female clients may suggest the need for a more in-depth review. Once the importance of screening is understood, clinicians will understand how screening for ADHD helps to inform the many symptoms associated with ADHD, and a diagnosis can be made to help the client receive the services they need and deserve. Clinical social workers are in a position to help their female clients make significant changes in their

lives. If female clients are screened for ADHD, and then if warranted, given the diagnosis they need to inform a treatment plan, this may yield better outcomes such as educational attainment, less poverty, and satisfying relationships, and social justice will be upheld.

Recommendation 3

The findings from this study might be useful to researchers seeking to develop screening measures that better identify a spectrum of predominant aspects of ADHD in women. For example, one finding suggests that the rate of stimulant use and abuse might be an item on a measure used to screen women for ADHD. The extent of illicit stimulant use which could alert both medical and mental health practitioners of what continues to be a "hidden diagnosis" (Quinn, 2015) in women. Several other findings might be reflected in items on Likert-type scales in a descriptive study that utilizes a survey approach to develop a screening instrument specific to women.

Recommendations for Dissemination of Findings

The findings of this study could be presented at the annual chapter and national NASW conferences. Findings from this study indicate opportunities for advanced training for clinical social workers on the use of screening instruments to explore further aspects that characterize ADHD in women. In turn, an advanced training workshop on screening women for ADHD could be offered at the annual local and national NASW conferences as well. The findings will be shared with the participants, and a one-page summary will be emailed to the participants.

Implications for Social Change

Services that clinical social workers use in practice with females are essential to

their well-being. Yet, little was known about how clinical social workers screen their female clients when signs and symptoms of ADHD are present. This study revealed a discrepancy in how clinical social workers screen for ADHD. If screening for ADHD is not properly understood and instituted, then women who may present with the signs and symptoms will not be explored and women will remain underdiagnosed. The major implication for social change will begin at the micro-level as the participants for this study were clinical social workers in private practice who experienced challenges in diagnosing their female clients with ADHD.

It is hoped that clinical social workers will become aware of the changes that are needed for their female clients to receive reliable and valid screening for ADHD. As such, these changes which inform how screening informs the proper assessment of ADHD their female clients need and deserve. In turn, it is with the hope that the findings will be further disseminated to other clinical social workers in both public and private mental health settings in northeast Massachusetts, at the mezzo-level, which may inform the need for a policy that mandates training in screening women with ADHD.

At the macrolevel of clinical social work practice, the diagnostic rates of females with ADHD will increase indicating the need for education around the importance of females who present signs and symptoms of ADHD to be properly screened and then diagnosed in order to receive the psychologically just treatment they need and deserve.

Summary

In this study, exploring how clinical social workers screen their female clients for ADHD revealed a gap in clinical practice.

The identified gap was the use of heuristic beliefs about ADHD in women, which may lead to overlooking the screening process required by clinical social workers in the assessment phase of clients. As a result, possible ADHD key components identifiable and unique for each female client worthy of further exploration may lead to assumptions and bias.

Therefore, the findings in this study indicated a need for updated information on the importance of using screening instruments, such as the ASRS- v1.1, as well as how screening may help to inform how signs and symptoms of ADHD present through time in their adult female clients. Additionally, clinical social workers will become more aware of the importance of an ADHD diagnosis at the micro, mezzo, and macro levels for their female clients to receive the psychologically just and evidence-based mental health services they need and deserve.

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