CLINICAL PRACTICE

Adult Attention Deficit–Hyperactivity Disorder

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This Journal *feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors' clinical recommendations.*

SUMMARY

Attention deficit–hyperactivity disorder (ADHD) is a medical condition that is present in approximately 2.5% of adults worldwide and manifests in a variety of different ways across the lifespan. Adults with ADHD often have coexisting psychiatric disorders such as anxiety, mood, sleep, substance use, and personality disorders and are at increased risk for coexisting somatic conditions such as obesity, cardiovascular and cerebrovascular disease, type 1 and type 2 diabetes, and immune and inflammatory conditions. Hence, such adults may be seen by clinicians providing care for a wide range of psychiatric and somatic conditions. Nevertheless, ADHD remains unrecognized and undiagnosed in many persons. Assessment requires interviewing of the patient for core ADHD symptoms, coexisting conditions, and their functional effects, which can be facilitated by using standardized rating scales. Key components of treatment are psychoeducation and psychostimulant or nonstimulant medication, mostly in combination with psychosocial interventions and lifestyle guidance.

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CME

A 38-year-old woman presents with job burnout after not having a response to earlier cognitive-behavior therapy for fear of failure at work and emotional instability. She struggles as a journalist with procrastination, failure to meet deadlines, and difficulty in finishing her writing assignments. These behaviors have not only caused substantial problems at work; her inability to manage details and stick to a schedule are also present at home and negatively affect her marriage and her ability to parent. She has difficulty sleeping and has obesity. How would you evaluate and treat this patient?

THE CLINICAL PROBLEM

Attention deficit–hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by developmentally inappropriate and impairing symptoms of inattention or hyperactivity–impulsivity (see the

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interactive graphic). Although ADHD has long been considered to be a childhood-limited condition, numerous follow-up studies have shown a persistent course into adulthood in at least one third of cases and lasting functional impairments in an even larger proportion.[1]

Although the core symptoms as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (DSM-5-TR)[2] (Table 1), are the same in children and adults, the symptom threshold is lower for adults and the clinical presentation typically differs from that in children. In addition to distractibility and forgetfulness in daily activities, inattentive symptoms often include the inability to plan and organize activities and poor time management. From adolescence onward, hyperactivity most often manifests as inner restlessness and an inability to relax and engage in leisure activities quietly. Impulsivity in adults typically manifests as blurting out impulsive comments, interrupting others, and making impulsive decisions (e.g., spending money carelessly). More severe and impairing manifestations of impulsivity, such as "road rage" or antisocial behavior, can also be seen.

Inattentive, restless, or impulsive behaviors sometimes occur in every adult and are also often present in other psychiatric disorders, such as anxiety and mood disorders, substance use disorders, personality disorders, and autism. These other psychiatric disorders merit consideration in differential diagnosis but also often co-occur with adult ADHD. A minority (10 to 40%) of adults with ADHD have no other psychiatric coexisting conditions (Table S1 in the Supplementary Appendix, available with the full text of this article at NEJM.org).[3]

Symptoms of adult ADHD should be differentiated from typical behavior by their association with functional impairment, which is often apparent in multiple domains, such as underperformance at work or in higher education, problems in interpersonal relationships, impaired parenting, financial problems, accident proneness, and repeated driving accidents. When ADHD occurs in gifted persons, it is important to consider whether there is underperformance relative to the person's cognitive potential. Disentangling whether impaired functioning is due to ADHD or other conditions ideally involves assessment of functioning in periods that are free of the other conditions.

ADHD is frequently associated with somatic conditions such as obesity, cardiovascular and cerebrovascular disease, type 1 and type 2 diabetes, and immune and inflammatory conditions. Shared genetic factors explain a large part of these associations, together with common neurobiologic mechanisms, highlighting a complex interplay between physical and mental health. ADHD is often associated with an earlier onset and worse outcome of these somatic conditions, patient delay in seeking medical attention, and nonadherence to recommended treatments.[4,5]

There are differences between men and women in the clinical presentation and recognition of ADHD. ADHD is often diagnosed at a later age in women than in men. Girls with ADHD are in general less disruptive than boys with ADHD and tend to compensate for or mask their symptoms. Women with ADHD more often seek evaluation for symptoms of anxiety and depression than men with ADHD, and ADHD is often missed as the primary or coexisting diagnosis.[6] Hormonal changes that are associated with the onset of puberty, the menstrual cycle, oral contraceptive use, pregnancy and the postpartum period, and menopause have been associated with changes in attention and impulsivity that may resemble ADHD or lead to increased severity of ADHD.[6] Emotional dysregulation is not part of the core defining symptoms but is present in most adults with ADHD. Such dysregulation may manifest as excessive short-lived exaggerated responses to affective cues, irritability, or verbal aggression.

The prevalence and severity of ADHD show an age-dependent decline, with an estimated worldwide prevalence of 5.3% in children and 2.5% in young adults. Rates among men and women are approximately equal in adulthood.[7] The estimated life expectancy of persons with ADHD is shorter by 7 years for men and 9 years for women than that of matched controls without ADHD.[8] Adults with ADHD often have an unhealthy lifestyle (with respect to nutrition, physical activity, smoking, and use of substances) and are more likely to struggle with educational underattainment, unemployment, financial

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Table 1. Summary of DSM-5-TR Criteria for Adult Attention Deficit–Hyperactivity Disorder (ADHD).*

Overall diagnostic criteria
Five or more symptoms of inattention or five or more symptoms of hyperactivity–impulsivity in persons 17 years of age or older (the threshold is six or more symptoms in persons younger than 17 years of age)
Several symptoms present by 12 years of age
Several symptoms present in two or more settings
Symptoms present for 6 months or longer
Several interfere with or reduce quality of social, academic, or occupational functioning
Symptoms are not better explained by another condition, such as depression or substance use disorder
Inattention (nine symptoms)
Lack of attention to details or makes careless mistakes
Difficulty sustaining attention
Does not listen when spoken to directly
Difficulty completing or finishing tasks or jobs
Problems organizing tasks and activities.
Avoids or dislikes sustained mental effort
Loses and misplaces things
Easily distracted
Forgetful in daily activities
Hyperactivity–impulsivity (nine symptoms)
Fidgeting (hands or feet) or squirming in seat
Leaves seat when remaining seated is expected
Restless or overactive
Difficulty engaging in leisure activities quietly
Always "on the go"
Talks excessively
Blurts out answers before questions have been completed
Difficulty waiting in line or taking turns
Interrupts or intrudes on others when they are working or busy

* DSM-5-TR denotes *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision.

problems, social relationship and marital problems, stigma, discrimination, accident proneness, repeated traffic violations, contact with the criminal justice system, and homelessness.[3,9] Some, however, can thrive by building on strengths such as creativity, a high energy level, drive, and enthusiasm.

ADHD is a polygenic and multifactorial neurodevelopmental condition with a heritability of approximately 80%.[1] Both common and rare genetic variants influence early neuronal development, synaptic transmission and regulatory pathways, and brain structure and function.[1,10,11] Persons with ADHD perform more poorly on executive function tasks such as planning, inhibition, working memory, and attentional tasks than unaffected persons. They also respond differently to rewards by preferring small immediate rewards over larger delayed rewards and have difficulty maintaining appropriate levels of cortical arousal.[1,12] Many of the brain regions implicated in ADHD are modulated by dopamine and noradrenaline, which are also the neurotransmitters that are targeted by ADHD medications. However, serotonergic mechanisms may also be implicated, and some new ADHD medications also target serotonin. Elevated risk of ADHD has been associated with many environmental factors, such as low birth weight, prematurity, psychosocial adversity (including abuse, neglect, and poverty), prenatal exposure to substances such as alcohol and nicotine, and exposure to environmental toxins such as lead and traffic-related air pollution, although causality for most of these factors has not been established[9,13] (Fig. 1).

Adults with ADHD who have not previously received a diagnosis usually enter the health care system by one of four routes: a visit to a general practitioner or other frontline professional because of impairing ADHD symptoms, often leading to referral for more specialized care; the seeking of treatment for a psychiatric condition that is often coexisting with ADHD; receipt of care for somatic conditions that co-occur with ADHD, while ADHD may remain undiagnosed;

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and Internet- and social media–inspired self-referral and self-diagnosis.

STRATEGIES AND EVIDENCE

ASSESSMENT

ADHD is a clinical diagnosis; there is no laboratory test that can be used to make the diagnosis, although neuropsychological tests can aid in characterizing it. Assessment of adult ADHD requires interviewing of the patient. Rating scales can be used to more accurately collect information about current and retrospective core symptoms and domains of function (see Table S2 for examples). In addition, obtaining information from another informant (partner, significant other, or parent)

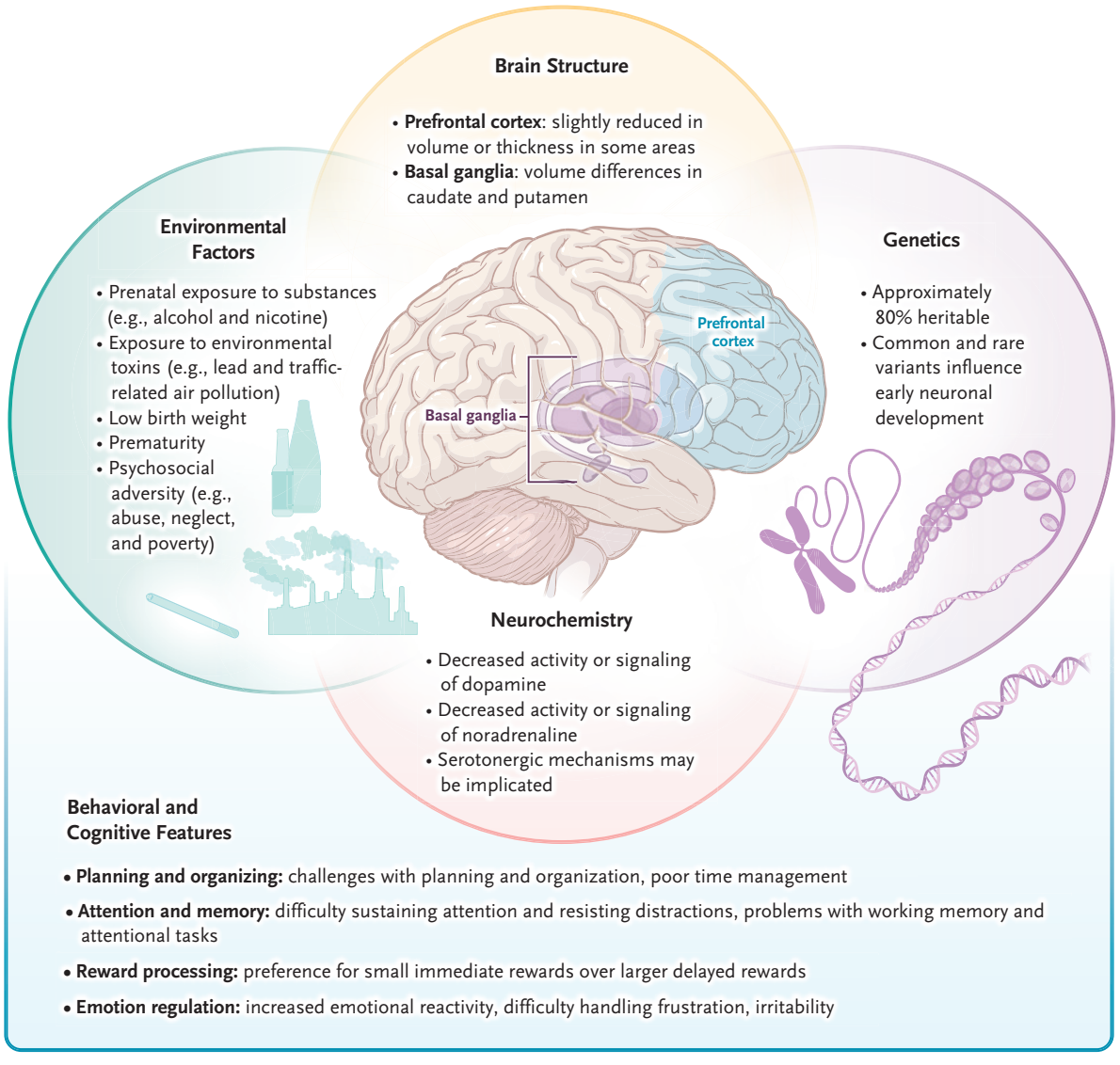


Figure 1. Neurobiologic Mechanisms of Attention Deficit–Hyperactivity Disorder (ADHD).

Persons with ADHD have differences in neurotransmitters, brain circuits and structure, genetics, and environmental factors as compared with persons without ADHD. The differences affect regulation of attention, behavior, and emotions. Note that the overlap of differences in brain structure among persons is large and that these are group-level trends, not diagnostic tests.

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about current and past symptoms and impairments is recommended. A particular challenge in assessing adults is the inconsistent recall of childhood symptoms, which may be unnoticed and reported as being absent in persons who have a supportive family or school environment, low cognitive demands, or high intelligence — or in those who do not accept the diagnosis.[14] Many persons with so-called late-onset impairing ADHD-like symptoms have these exclusively in the context of heavy substance use or another psychiatric condition and therefore should not receive the diagnosis.[15]

It is essential to assess the context in which ADHD occurs, including marital, parental, and social capacities and the effect of ADHD on self-concept and self-esteem. It is also important to assess associated features that are frequently present in persons with ADHD, including emotional dysregulation, executive dysfunction (e.g., problems with organization and time management), and sleep, substance use, and other psychiatric and somatic coexisting conditions.

DIAGNOSIS

Diagnosis is based on the criteria laid out in the DSM-5-TR[2] (Table 1). Persons 17 years of age or older must have at least five of the nine inattention symptoms or at least five of the nine hyperactivity–impulsivity symptoms for the diagnosis to be made. Symptoms of ADHD must be distinguished from those of other psychiatric disorders. For example, generalized anxiety disorder may be complicated by agitation and restlessness, in addition to inattention to salient stimuli. However, these symptoms generally occur in response to anxiety-producing stimuli. Decreased concentration and poor academic achievement are frequently present in persons with major depression and other mood disorders. However, depressive disorders are often episodic, and when academic underattainment is present, it is more often acute in depression than in ADHD. It is important to assess for ADHD in adults with treatment-resistant depression, because this can confound treatment response.[16]

TREATMENT

The aim of ADHD treatment is to target the core symptoms of inattention and hyperactivity–impulsivity as well as associated cognitive, social, and psychological impairments. These should be tracked as treatment proceeds; symptom-based scales offer an efficient way to do this. A clinically meaningful response typically requires a 40 to 50% change in symptoms.[17] Available treatment options include pharmacologic and psychosocial approaches. Medication is most effective for reducing core symptoms[18] but can also have benefits with respect to behavioral nonadherence, emotional lability, social interactions, academic and task-related efficiency and accuracy, executive function, family dynamics, self-esteem, and quality of life. Psychoeducation is important in helping patients understand that ADHD is a neurobiologically based medical condition that manifests in a variety of different ways across the lifespan and in helping them appreciate the nature of symptoms and the many ways they can affect individual patients.[19]

A variety of stimulant and nonstimulant medications are approved for adults by the Food and Drug Administration (FDA) and European Medicines Agency. Most medication treatment is with the psychostimulants methylphenidate and amphetamine, each of which comes in immediate-release and longer-duration formulations (Tables 2 and 3). Most adults are treated with an amphetamine formulation, although either stimulant class can be used.[23] Adults with ADHD often find medication helpful in being active during work and after-work hours, so long-acting formulations are recommended. Such formulations can be expected to last 8 to 12 hours; however, one formulation (Mydayis brand amphetamine mixed salts) is labeled for up to 16 hours. Duration of action is slightly longer with amphetamines than with methylphenidate, owing to the longer half-life. Nevertheless, even the long-acting stimulants may not provide coverage that lasts all day; thus, supplementation with immediate-release medication may be helpful. It is important to adjust the dose of the medication, balancing symptomatic improvement and adverse effects; frequent follow-up visits are often needed until the optimized treatment effect is achieved.

The stimulants are Schedule II controlled substances. Hence, there has been concern as to whether stimulant treatment can increase the risk of substance abuse; however, the data do not support this view. The most recent meta-analysis[24] and the longitudinal follow-up of youth in the Multimodal Treatment of ADHD study[25]

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showed neither increased risk nor protective effects of stimulant treatment. Large studies based on Scandinavian registries[26] and insurance claims[27] showed that stimulant treatment was associated with a decreased risk of substance abuse. Consequently, treating persons with ADHD and substance abuse with stimulants is possible and may be preferred. Nevertheless, stimulant medications can be misused or diverted to others; this is particularly true of immediate-release stimulants. Most of the misuse is in young adults, especially high school and college students,[28] for perceived academic or occupational need; however, some amount of misuse is for the purpose of generating euphoria.[29] Because substance use disorders are more common among persons who misuse stimulant medication, it is important to monitor for misuse.[30]

Several approved nonstimulant medications are also available. Effect sizes for nonstimulants are in the moderate range (Tables 2 and 3) and somewhat lower than they are for stimulants. However, there is considerable variability in response.[31] Advantages of nonstimulants as compared with stimulants include their uncontrolled status, longer duration of action, and lack of abuse liability.[32] There are currently three nonstimulant classes — the norepinephrine-reuptake inhibitor (NRI) atomoxetine, the NRI–serotonin (5-HT) modulator viloxazine (available only as an extended-release formulation), and the long-acting formulations of the α_2 adrenergic agonists clonidine and guanfacine. A triple (norepinephrine–serotonin–dopamine) reuptake inhibitor (centanafadine)[33] was recently approved by the FDA; however, it has not yet received a schedule from the Drug Enforcement Administration. The α_2 agonists are labeled for use in children and not adults, although extended-release guanfacine is labeled for adults in Japan on the

Table 2. Treatments for ADHD in Adults.*

Psychoeducation
Essential on beginning treatment; can be done by the prescriber or someone else on the team.

Evidence-based psychosocial treatment
Cognitive-behavioral therapy targeted to ADHD involving cognitive restructuring, metacognitive therapy, organizational-skills training, and dialectical behavior therapy; can be done in individual or group setting; depends on availability of skilled provider.
Effect sizes: global functioning, 0.47; occupational functioning, 1.00; social relationships, 0.36; academic functioning, 0.48; quality of life, 0.28.[20]

Stimulant medication
Methylphenidate and amphetamine classes are both approved; can start with either; often recommended as a first-choice option.
Effect sizes (core ADHD symptoms): The latest network meta-analysis in adult ADHD showed the effect size for both stimulant classes together, with no significant difference between the classes: 0.39 for patient-rated symptoms and 0.61 for clinician-rated symptoms.[18]

Nonstimulant medication
Three classes of Food and Drug Administration (FDA)–approved medications are potentially available: norepinephrine-reuptake inhibitor (NRI) (atomoxetine), NRI–serotonin modulator (extended-release viloxazine), and the α_2 agonists (extended-release guanfacine and extended-release clonidine). A fourth class — triple reuptake inhibitor (centanafadine)† — was recently approved for children and adults by the FDA but has not yet been scheduled by the Drug Enforcement Administration. The α_2 agonists are FDA-approved in children and adolescents but not adults and are used on an off-label basis; bupropion is also often used off-label. Nonstimulants are often a second-choice option in most guidelines, although efficacy is similar to that of stimulants in selected persons.
Effect sizes (core ADHD symptoms): A recent meta-analysis showed a moderate effect size for atomoxetine (15 randomized, controlled trials [RCTs]; effect size, 0.48) and guanfacine (2 RCTs; effect size, 0.66). The effect size for extended-release viloxazine is in the same range but with only 1 RCT to date.[21] Another meta-analysis showed a modest effect size for centanafadine (5 RCTs; effect size, 0.37).[22]

Other
Available evidence indicates that devices, therapeutic games, and neuromodulation lack efficacy with respect to core ADHD symptoms but may affect overall function. They are not recommended as primary treatment methods. There are few studies on the effects of diets and supplements on core symptoms in adult ADHD.

* An effect size is a quantitative standardized measure of the magnitude of a difference between cohorts or intervention groups. Conventional thresholds of effect size are as follows: 0.2 is small, 0.5 is moderate, and more than 0.8 is large.
† Centanafadine awaits scheduling by the Drug Enforcement Administration (expected in October 2026). The product label describes this medication as a stimulant, so it is likely to be scheduled. However, it may receive a lower schedule than the current stimulants used for ADHD.

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basis of positive findings in a controlled clinical trial.[34]

The most common adverse effects of stimulants include decreased appetite and weight, initial insomnia, and increased heart rate and blood pressure. Long-term treatment carries some increased risk of cardiovascular disease, primarily hypertension.[35,36] Consequently, baseline screening for cardiovascular disease is recommended. Such screening entails a medical and family history taking for preexisting cardiovascular conditions; a physical examination with measurement of resting blood pressure, pulse, and weight; and an electrocardiogram if there are clinically significant findings in the medical history, physical examination, or family history.

Stimulants can have either a positive or negative effect on mood; irritability either at peak blood level or medication wear-off is not uncommon. Affective blunting, or feeling less interactive and emotionally flat, can also be seen. There is a very low level of risk for psychotic symptoms, most likely among vulnerable persons or with higher-dose treatment, but no particular risk for the development of psychotic level disorders.[37,38] Adverse effects of nonstimulants differ as a function of drug class. However, most are associated with some degree of sedation on starting the medication or increasing the dose. Appetite is less often affected than with stimulants, but the NRIs can cause nausea. The NRIs can increase heart rate and blood pressure, whereas the α_2 agonists decrease heart rate and blood pressure. Managing adverse effects is important — not only for patient safety and treatment acceptability but because they can lead to inadequate doses, poor medication adherence, or both.[39]

An important related issue is whether ADHD medication is safe during pregnancy and lactation. Risk of teratogenicity is low,[40] as is risk of offspring neurodevelopmental disorders.[41] There are small increased risks of low weight and preeclampsia, which may be relevant for women at risk for these conditions.[40] Medication use during

Table 3. Tips on Optimizing Medication Treatment.

Overall
Begin with psychoeducation.
Engage patients regarding goals of treatment and allow them to participate in treatment selection once appropriately educated.
Identify target symptoms — two or three individualized items that need to change and represent targets of treatment — across settings and time of day.
Choose an FDA-approved medication: stimulant or nonstimulant (understanding that stimulants on average offer somewhat superior response and are recommended as a first option in most guidelines).
Frequent visits on starting medication; use symptom-based scales.
Aim for excellent response (40–50% decrease in ADHD symptoms) and good-to-excellent treatment acceptability. Improvement in target symptoms is essential.
Monitor for adverse events, treatment acceptability, and adherence; be alert to any indications of misuse or diversion of medication.
Monitor for substance use.
Consider addition of evidence-based psychosocial treatment either at the outset or if there are residual symptoms or problems with organization or executive functions despite medication.

Stimulants
Determine what times of the day need to be covered.
Begin with a long-acting stimulant formulation in either class.
Consider alternative formulations or addition of immediate-release stimulant if duration is not optimal; usually, this is known quickly.
Make sure to test higher doses because it is not always apparent what the optimal response is.
Switch to the other stimulant class if response or treatment acceptability is not optimal.
Consider switching to or adding a nonstimulant for patients with a partial response or those with side effects at needed doses.

Nonstimulants
Begin with an FDA-approved medication (NRI or NRI–serotonin modulator, or triple reuptake inhibitor).
Determine desired target dose with the use of weight-based calculations if indicated.
Increase dose to the expected range before deciding whether the medication is effective.
Determine whether there is at least an entry level response by 2–4 weeks.
Consider switching to or adding another nonstimulant or a stimulant if there is inadequate response or acceptability.
Consider using non–FDA-approved medications with demonstrated efficacy (e.g., α_2 or bupropion) if there is inadequate response or acceptability with FDA-approved medications or if there are coexisting conditions.

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Table 4. Professional Guidelines for Assessment and Treatment of Adult ADHD.

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Canada: Canadian ADHD Resource Alliance (https://www.caddra.ca/wp-content/uploads/Canadian-ADHD-Practice-Guidelines-4.1-January-6-2021.pdf)
Australia: Australasian ADHD Professionals Association (https://aadpa.com.au/wp-content/uploads/2026/01/Australian-Clinical-Practice-Guideline-For-ADHD-Updated-January-2026.pdf)
United States: guidelines forthcoming from American Professional Society of ADHD and Related Disorders (https://www.apsard.org)

lactation is generally considered to be safe, because transmission levels are very low — especially for methylphenidate.[40] Taken together, current guidelines recommend psychosocial intervention for mild ADHD during pregnancy and medication use for moderate-to-severe ADHD.

Nonpharmacologic interventions are also available (Table 2). Evidence-based psychosocial treatment for adults uses cognitive-behavioral therapy (CBT) approaches, including cognitive restructuring, meta-cognitive therapy, organizational-skills training, and dialectical behavior therapy.[42-44] These interventions are important for adults, because inattention symptoms and poor organization predominate, and the latter may be less adequately treated with medication. The latest meta-analysis showed that CBT has moderate positive effects on a variety of functional domains and limited effects on core symptoms and quality of life.[20] Neurofeedback has been studied in adult ADHD; however, the data have not been encouraging. Given the range of impairments that is frequently present, a combination of medication and psychosocial treatment approaches is often required.

GUIDELINES

Current professional guidelines for the assessment and treatment of ADHD in adults are very much aligned (Table 4). A clinical interview with the patient is considered to be essential. ADHD should not be diagnosed solely on the basis of rating scales; however, rating scales offer an efficient means of obtaining information about core symptoms, functional impairments, and coexisting conditions. Existing guidelines converge in recommending treatment with either psychostimulant class as the first-line option for core ADHD symptoms; however, nonstimulants can also have an important role. Psychosocial treatments should be considered for adults who make an informed choice not to use medication, when medication is insufficiently effective or has unacceptable side effects, or to target domains of functional impairment outside the core symptoms.

AREAS OF UNCERTAINTY

ADHD is misdiagnosed, underdiagnosed, or diagnosed late in women more often than in men.[6] High-quality large-scale studies are needed to examine what characterizes the ADHD phenotype in women, how this changes over development, and whether a sex-specific diagnostic algorithm should be established. More data are needed on the effects of the menstrual cycle on medication dose and whether initiation of treatment in perimenopausal and postmenopausal women with new onset or exacerbation of attentional symptoms should be considered.

ADHD is associated with an increased risk of mild cognitive impairment, dementia, and Parkinson's disease at older ages, although the links become weaker with control for co-occurring psychiatric disorders.[45] Further studies are needed to elucidate the association between ADHD and mild cognitive impairment and whether stimulant medication is a protective or risk factor.

It is unclear what role digital phenotyping, digital monitoring, digitally delivered behavior therapy, and digital planners and support apps can play in the management of adult ADHD.[46,47] Physical exercise also requires more research, given promising effects in improving inhibitory control and core symptoms.[48] More data are needed about the effects of medication treatment on long-term outcomes, whether to prioritize stimulants or nonstimulant approaches, and how to best treat ADHD in the context of coexisting disorders, including mood, anxiety, and substance use disorders.

CONCLUSION AND RECOMMENDATIONS

The case illustration describes a woman who first draws attention for burnout and performance-related anxiety, but on closer inspection also has

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KEY POINTS

ADULT ATTENTION DEFICIT—HYPERACTIVITY DISORDER (ADHD)

- ADHD is a medical condition that manifests in a variety of different ways across the lifespan.
- Adults with ADHD may be seen by clinicians providing care for a wide range of psychiatric and somatic conditions, although ADHD remains unrecognized and undiagnosed in many persons.
- Many adults with ADHD have complex psychiatric and medical histories.
- The key components of treatment are psychoeducation and psychostimulant or nonstimulant medication, mostly in combination with psychosocial interventions.

symptoms of ADHD. Yet, this patient has never been diagnosed with ADHD or treated for this condition — a common occurrence. To best assess and treat this patient, it is essential to recognize the possibility that ADHD could be present; interview her and systematically assess the frequency, severity, and effect of ADHD symptoms with the use of a DSM-based rating scale; gather collateral information from her partner or parent; and assess for the presence of psychiatric and physical coexisting conditions. We would diagnose this patient with ADHD and coexisting generalized anxiety disorder and would prioritize ADHD treatment, because the ADHD symptoms precede and underlie the anxiety. We would educate the patient and her partner about ADHD and prescribe long-acting psychostimulant medication or a nonstimulant medication (which might also address the coexisting anxiety). We would expect treatment of ADHD symptoms to improve the ability to meet deadlines and enable the patient to better organize work and family life and thereby decrease anxiety. We would follow up frequently — every 2 to 4 weeks until the patient's condition is stable. If there are residual ADHD impairments after the medication dose is optimized, we would consider changing to or augmenting with a different medication or adding organizational-skills training. After the ADHD symptoms abate, we would reassess the level of anxiety. Psychosocial treatment for anxiety disorders is quite effective and would probably be the first choice if treatment for anxiety is to be added; however, a variety of medications, including selective serotonin-reuptake inhibitors, could also be used together with ADHD treatments.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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