

ADHD and Anxiety: Untangling Overlap and Planning Integrated Care

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Narrative Clinical Review

Abstract—Attention-deficit/hyperactivity disorder (ADHD) and anxiety disorders commonly coexist in adults, and several complaints—including poor concentration, procrastination, restlessness, and overpreparation—can arise from either condition. Their diagnostic value depends less on the complaint itself than on its developmental course, triggers, function, and consequences. This narrative clinical review synthesizes evidence relevant to differential diagnosis and proposes a parallel-timeline and episode-sequence framework for integrated care. Assessment first reconstructs ADHD and anxiety histories separately, then examines recent episodes to determine how weak task activation, attentional capture, threat appraisal, avoidance, compensatory behavior, and environmental consequences unfold. Screening scales can organize inquiry but cannot establish developmental onset or identify the operative process. Treatment priority should reflect risk, severity, impairment, patient preference, and whether one condition obstructs care for the other. Medication effects on anxiety vary: anxiety related to repeated ADHD-associated failures may lessen as attention and functioning improve, whereas activation, insomnia, or distressing autonomic sensations may aggravate anxiety in some patients. Direct evidence for specific comorbid anxiety disorders remains limited, making gradual titration and separate monitoring important. Psychotherapy should retain the active mechanism of the anxiety treatment while reducing avoidable executive demands through visible structure, shorter tasks, written plans, rehearsal, and environmental support. Sleep, substance use, physical health, trauma-related presentations, and bipolar disorder require active consideration. The central clinical principle is diagnostic differentiation with therapeutic integration: distinguish the processes closely enough to make sound decisions, then coordinate care around their interaction in everyday life.

Index Terms—adult ADHD, anxiety disorders, comorbidity, differential diagnosis, functional formulation, integrated care

I. INTRODUCTION

“I cannot concentrate” is clinically important but diagnostically incomplete. Attention may be diverted by a passing stimulus, captured by anticipated threat, degraded by sleep loss, narrowed by trauma-related vigilance, or abandoned when a task is difficult to organize. Adults with ADHD, anxiety, or both may report the same surface complaint. Assessment therefore has to establish what is drawing attention away, under which conditions, and in what sequence.

Large population studies confirm substantial psychiatric comorbidity in adult ADHD. A methodological review and meta-analysis of large datasets estimated approximately fivefold higher pooled odds of anxiety disorders among adults with ADHD than among adults without ADHD, while emphasizing that ascertainment and diagnostic methods affect the estimate (Hartman et al., 2023). The finding supports routine screening, not an assumption that anxiety necessarily follows from ADHD.

The conditions can reinforce one another. Missed messages, unfinished work, impulsive decisions, and inconsistent performance create genuine uncertainty and interpersonal consequences. Worry then occupies attention, avoidance grows, and task initiation becomes still harder. Some adults compensate through exhaustive checking or last-minute effort and appear organized only at substantial internal cost. A useful formulation therefore includes the reciprocal maintenance cycle as well as the diagnostic criteria.

This review addresses adult assessment and treatment planning. It is not a medication protocol and does not replace a full developmental, psychiatric, medical, and risk evaluation. Clinically, it recommends reconstructing the developmental course of ADHD and anxiety separately, examining the sequence of processes in recent episodes, and setting treatment priorities according to risk, impairment, patient preference, and interference with care.

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II. SCOPE AND REVIEW METHOD

The literature search for this narrative clinical review closed on 30 August 2025. Sources were selected for clinical relevance and strength of evidence, with emphasis on consensus statements, clinical guidance, systematic reviews, meta-analyses, randomized adult trials, and studies of direct comorbidity. Complete online-first publications available by the cutoff were eligible. No new systematic review or meta-analysis was undertaken.

ADHD and anxiety are heterogeneous. Adult ADHD varies in the prominence of inattention, hyperactivity, impulsivity, emotional dysregulation, developmental course, compensation, and impairment. Anxiety-related presentations include generalized worry, panic, social-evaluative and phobic threat, obsessive-compulsive symptoms, trauma-related responses, illness anxiety, and symptoms associated with substances or medication. Findings from one comorbid pairing should not be applied automatically to another.

Recent syntheses were considered alongside earlier work. A 2025 component network meta-analysis included 113 randomized adult ADHD trials and 14,887 participants, although its search covered studies only through September 2023 (Ostinelli et al., 2025). A 2025 narrative review addressed adult ADHD with anxiety and depression and was useful for clinical integration, but it provides narrative synthesis rather than comparative trial evidence (Fu et al., 2025).

Throughout this review, evidence for core ADHD symptoms, evidence for specific anxiety disorders, and direct evidence from comorbid samples are kept distinct. Recommendations that adapt established treatments in the absence of direct comorbidity trials are identified as such. The strength of each claim should remain proportionate to the evidence on which it rests.

III. PATHWAYS TO CO-OCCURRENCE

ADHD is a neurodevelopmental disorder characterized by developmentally inappropriate and impairing inattention and/or hyperactivity-impulsivity across settings. In adults, presentation is shaped by developmental change, current demands, and compensation: overt motor activity may become inner restlessness, whereas organizational impairment often becomes more visible when external structure recedes (Faraone et al., 2015; Kooij et al., 2019). Evidence of childhood onset remains necessary even when recognition occurs decades later.

Anxiety disorders involve excessive fear or anxiety and associated avoidance organized around particular threats and contexts. Attention may be sharply focused on threat while becoming unavailable for the competing task. Anticipatory worry, bodily arousal, reassurance seeking, and avoidance

help identify the process, although no single feature is diagnostic (Craske et al., 2017). Anxiety may precede recognition of ADHD, develop after repeated adverse experiences associated with ADHD, or arise independently.

Several vulnerabilities may be shared or mutually reinforcing, including genetic liability, difficulties in emotional regulation, intolerance of uncertainty, sleep disruption, and repeated negative feedback. The 2025 comorbidity review describes biological, cognitive, and psychosocial pathways but also underscores their complexity; no single causal pathway explains the full pattern (Fu et al., 2025). Developmental learning matters as well: a child who repeatedly loses or fails to submit work may come to experience every deadline as a threat.

Emotional dysregulation is prominent in many adults with ADHD, but it is not itself an anxiety disorder. Rapid frustration, heightened sensitivity to criticism or rejection, and slow recovery after activation may coexist with sustained worry or panic. In randomized trials, stimulants and atomoxetine produced moderate average improvement in emotional lability, smaller than their effects on core ADHD symptoms, although methods and measures varied (Moukhtarian et al., 2017). This pattern warrants targeted assessment rather than automatic diagnostic expansion.

IV. SIMILAR COMPLAINTS, DIFFERENT PROCESSES

A complaint becomes diagnostically informative only when its timing, triggers, context, and function are known. ADHD-associated distractibility tends to occur across emotional states and may follow novelty, external stimulation, competing thoughts, or low task salience. Anxiety-associated concentration difficulty often intensifies with threat because attention is directed toward worry, scanning, imagery, or bodily sensations. In comorbid presentations, the processes may occur together or in rapid sequence.

Procrastination illustrates the distinction. A person with ADHD may not begin until urgency supplies enough stimulation and structure. A person with anxiety may delay because beginning introduces the possibility of error, judgment, uncertainty, or irreversible commitment. With both conditions, failed initiation may trigger anxiety about the delay, prolonged recovery planning, and crisis-driven completion. Treatment aimed only at motivation or only at anxious beliefs may therefore leave the sequence partly intact.

Restlessness may reflect longstanding hyperactivity, anxious arousal, medication or caffeine effects, akathisia, sleep deprivation, or mood elevation. Rapid speech may be lifelong, situational, substance-related, or episodic within a bipolar presentation. The differential rests on course and context rather than intensity during a single consultation. Collateral information and earlier records can reduce

uncertainty when available and obtained with consent; their absence does not decide the diagnosis.

Table 1. Common complaints, contrasting mechanisms, and clarifying questions

Presenting complaint	ADHD-associated pattern	Anxiety-associated pattern	Questions that clarify
Poor concentration	Broad distractibility; weak task salience; attention varies with interest	Attention captured by worry, threat cues, or bodily sensations	What occupies attention? Does difficulty persist when threat is low?
Procrastination	Initiation or sequencing difficulty; urgency dependence	Avoidance of error, evaluation, uncertainty, or distressing sensations	What blocks the first step? What reliably enables action?
Restlessness	Longstanding motor or inner restlessness across contexts	Arousal linked to anticipated or present threat	Was it present in childhood? What increases or reduces it?
Forgetting	Weak encoding, working memory, or prospective memory	Information not encoded because worry occupied attention	Was the information registered? Do external supports help?
Overpreparation	Compensation for expected disorganization	Safety behavior intended to prevent a feared outcome	What outcome is feared? What happens when preparation is reduced?

V. DIAGNOSIS REQUIRES PARALLEL TIMELINES

A practical assessment reconstructs two timelines before examining how they interact. The ADHD timeline traces childhood attention, activity, impulse control, school functioning, routines, work, driving, money management, relationships, and recurring communication difficulties such as missed messages, forgotten commitments, interrupting, or avoidance of clarification. The anxiety timeline traces the onset and themes of fear or worry, panic, avoidance, trauma exposure, social evaluation, reassurance seeking, and periods of remission. Points of convergence show where the conditions may have begun to interact.

Symptom scales can organize inquiry but cannot establish developmental onset or make a differential diagnosis. ADHD self-report scores are influenced by mood, sleep, stress, and the person's explanatory framework. The GAD-7 provides a brief measure of generalized anxiety symptom burden, but it does not distinguish ADHD-related overwhelm from generalized anxiety disorder and does not cover every anxiety presentation (Spitzer et al., 2006). Positive screens require clinical assessment; a negative screen should not end assessment when the history remains compelling.

Impairment should be documented across settings and over time. One person may function well at work because deadlines, interest, and accountability are high while home

administration collapses. Another may appear inattentive only in evaluative meetings because social anxiety captures attention. Diagnostic criteria require more than an isolated difficulty, and apparent success does not rule out impairment when it depends on excessive hours, avoidance of advancement, or substantial support from others.

Developmental inquiry must also allow for late recognition. ADHD may have been obscured by high ability, a highly structured household, anxiety-driven overcontrol, or a quieter inattentive presentation. At the same time, retrospective accounts are vulnerable to reconstruction. International consensus therefore recommends combining a developmental interview with evidence of impairment across settings, collateral sources where possible, and systematic consideration of alternatives (Kooij et al., 2019).

VI. FUNCTIONAL FORMULATION FOR INTEGRATED CARE

Diagnosis names a condition; functional formulation identifies a treatment entry point. Consider a poorly structured task. Initiation fails, time passes, and the risk of consequences increases. Anxiety then prompts checking, planning, reassurance seeking, or avoidance. Crisis-driven work erodes sleep, leaving attention and emotional regulation worse the next day. The cycle is maintained by several processes, and change in one may create room to address the others.

The clinician and patient can map a recent episode as a sequence: situation, shift of attention, prediction, bodily response, action, short-term relief, delayed cost, and environmental consequence. "I did nothing" becomes more precise: the person opened six files, switched repeatedly, imagined criticism, rewrote a list, avoided asking for clarification, and began at midnight. This level of detail reduces shame without minimizing impairment and reveals discrete intervention points.

Sequence mapping also prevents circular explanations. "I avoided because of ADHD" and "I avoided because of anxiety" are less useful than identifying what happened first: an unclear task impeded initiation, the delay triggered fear of being exposed, and reassurance seeking displaced action. Defining the first step may reduce executive demand; testing the feared prediction may address anxiety; agreeing on how to seek clarification may change the environment.

Compensatory strategies may protect function while imposing substantial cost. Rigid calendars, repeated checking, arriving extremely early, or never delegating can reduce immediate risk while increasing anxiety and burden. A strategy is clinically useful when it is reliable, proportionate, and sustainable. It should be replaced only when a simpler alternative can preserve function at lower cost.

Practical adaptations when attentional difficulties affect psychotherapy

- Set one agenda and one concrete session outcome; keep the formulation visible.
- Define between-session work as a first action that can begin within minutes.
- Use written summaries, reminders, environmental cues, and rehearsal, with consent.
- Practice the task in session; understanding the rationale does not guarantee implementation.
- Distinguish forgetting, initiation difficulty, threat-driven avoidance, and disagreement with the task.
- Review noncompletion without moral judgment and redesign the task when needed.

VII. SETTING TREATMENT PRIORITIES

There is no established universal rule that ADHD or anxiety should always be treated first. Priority should follow immediate risk, severity, functional impairment, patient preference, and whether one condition obstructs treatment of the other. Severe panic, obsessive-compulsive symptoms, acute trauma-related symptoms, substance withdrawal, suicidality, or mood instability may require urgent condition-specific care. In other cases, untreated ADHD may prevent consistent attendance, recall, organization, or practice within anxiety treatment.

Staging can still be integrated. The clinician selects one early target, introduces low-burden support for the other condition, and monitors both. ADHD medication, for example, may be titrated while the patient develops a brief panic formulation and reduces caffeine; anxiety-focused therapy may begin while reminders, appointments, and task design are adapted for ADHD. Staging reflects priority and feasibility, not neglect of the second diagnosis.

Shared decision-making should incorporate the person's previous experiences and concerns. Some patients have been told that anxiety explains everything; others have received an ADHD diagnosis that seemed to absorb grief, trauma, or realistic social threat. The clinician should explain the evidence for each formulation, what remains uncertain, which changes are expected from treatment, and what findings would prompt reconsideration.

Clinical guidance for adult ADHD recommends comprehensive assessment, attention to coexisting conditions, and treatment planning around impairment (National Institute for Health and Care Excellence, 2018). Consensus statements likewise emphasize multimodal care across the lifespan and reject diagnosis by checklist alone (Faraone et al., 2021). Integrated care coordinates specific interventions; it is not a vague attempt to address everything at once.

VIII. MEDICATION AND ANXIETY: INDIVIDUALIZED MONITORING

Patients and clinicians often ask whether stimulant treatment will worsen anxiety. The evidence supports neither a universal warning nor a universal reassurance. Anxiety may lessen when improved attention reduces task failure, uncertainty, and overload; it may worsen through activation, insomnia, or distressing autonomic sensations, particularly after rapid dose changes. Baseline anxiety, sleep, substance use, expectations, dose, and timing all matter. Repeated, separate measures of ADHD symptoms, anxiety, sleep, functioning, and adverse effects are more informative than a single global impression.

Across adult ADHD trials, stimulants and atomoxetine have the most consistent short-term evidence for core symptoms, although certainty varies and evidence on acceptability, quality of life, and longer-term outcomes remains limited (Cortese et al., 2018; Ostinelli et al., 2025). These syntheses were not designed to establish effects on every comorbid anxiety disorder. Improvement in ADHD symptoms should not be taken as evidence that anxiety has resolved, and greater productivity alone does not show that anxiety has improved.

Direct evidence from comorbid samples is sparse. In a 14-week randomized trial of 442 adults with ADHD and social anxiety disorder, atomoxetine improved both ADHD symptoms and Liebowitz Social Anxiety Scale scores relative to placebo (Adler et al., 2009). This finding supports atomoxetine as an option for that defined population; it does not establish a general anxiolytic effect for ADHD medication or across anxiety diagnoses.

Prescribing requires an individualized medical evaluation, discussion of alternatives, gradual adjustment when appropriate, and monitoring of blood pressure, pulse, sleep, appetite, substance-related risk, and mood. New agitation or a reduced need for sleep warrants assessment and should not automatically be labeled anxiety. When one domain improves and another worsens, dose, timing, formulation, diagnosis, and parallel treatment should be reconsidered rather than collapsed into a single overall verdict.

IX. PSYCHOTHERAPY AND EXECUTIVE SUPPORT

Psychotherapy for adult ADHD commonly combines psychoeducation with organization, planning, problem solving, management of distractibility, and work on demoralization and unhelpful beliefs. Randomized trials of cognitive-behavioral and metacognitive approaches have found benefits for persistent adult ADHD symptoms, including in medicated participants (Safren et al., 2010; Solanto et al., 2010). A meta-analysis also supports CBT while noting substantial heterogeneity across interventions and studies (Young et al., 2020).

Treatment of anxiety must remain specific to the presentation: exposure and response prevention for obsessive-compulsive disorder is not interchangeable with treatment for panic, trauma, or generalized worry. Adaptations for ADHD should preserve the active therapeutic mechanism. An exposure task may be shorter and cued, but it must still involve contact with the relevant fear and reduction of safety behavior. A written plan can support memory; it cannot substitute for the task.

Sessions benefit from visible structure: a brief agenda, review, one formulated problem, in-session practice, a written summary, and a between-session action tied to a time and place. With consent, the patient may photograph a whiteboard, use a reminder application, or involve a support person. These adjustments reduce executive load so that the intended psychological learning can occur.

Shame often develops where the conditions intersect. Years of being called “careless,” “lazy,” or “too sensitive” can make any task that might confirm those judgments feel threatening. A compassionate stance remains precise and accountable: it describes behavior accurately, tests predictions, designs workable supports, and distinguishes a failed strategy from a failed person. That distinction often makes experimentation possible.

X. SLEEP, SUBSTANCE USE, PHYSICAL HEALTH, AND DIFFERENTIAL DIAGNOSIS

Sleep disturbance can mimic and amplify inattention, restlessness, irritability, and anxiety. Assessment should cover schedule and variability, insomnia, delayed sleep timing, sleep-apnea risk, restless legs, nightmares, and the timing of medication, caffeine, nicotine, alcohol, and other substances. Cognitive-behavioral therapy for insomnia has a strong adult evidence base, but practical adaptations may be needed when routines and prospective memory are impaired (Trauer et al., 2015).

Caffeine or nicotine may be used to regulate attention while increasing bodily arousal; alcohol or sedatives may reduce social or evening anxiety while worsening sleep and executive control. Cannabis may be experienced as calming yet impair memory, motivation, or performance in some people. Inquiry should cover function, amount, timing, tolerance, withdrawal, and interaction with prescribed treatment, without moral judgment.

Medical and psychiatric alternatives remain important. Thyroid disease, anemia, pain, menopausal symptoms, cardiopulmonary illness, medication adverse effects, and neurological conditions can alter attention or arousal. Bipolar disorder requires particular care when there are episodic changes in the need for sleep, energy, confidence, speech, risk-taking, or goal-directed activity. Trauma-related disorders, autism, learning disorders, and obsessive-

compulsive symptoms may coexist with ADHD or anxiety; their presence does not exclude either diagnosis.

Risk should be assessed directly. Comorbidity can increase burden, and late recognition may follow years of failure or invalidation. Inquiry should include hopelessness, self-harm, impulsive risk, interpersonal violence, and substance-related harm. Safety plans should be concrete and usable under stress: brief written steps, minimal practical barriers, named contacts, and explicit attention to whether executive difficulties might prevent implementation.

XI. MONITORING AN INTEGRATED PLAN

Monitoring should separate domains so that change can be interpreted. A compact set may include one ADHD measure, a presentation-matched anxiety measure, sleep, adverse effects, and two functional outcomes such as beginning work, attending appointments, or entering a feared situation. Measures should be repeated at useful intervals and reviewed alongside the person's account. A total score is evidence, not a substitute for clinical interpretation.

The plan should state the expected sequence of change. If external task structure improves first, anxiety may temporarily become more visible as the person approaches previously avoided work. If anxiety falls, persistent time-management difficulties may become easier to see. Mixed change is clinically informative; it argues against judging the entire treatment by one symptom cluster.

Follow-up should also assess treatment burden. Elaborate productivity systems may collapse; exposure homework may become another source of deadline shame; medication benefit may be offset by insomnia. Treatment should favor the least complex support that remains effective and review what the person actually used, including the effort required.

Table 2. Monitoring change and treatment burden

Domain	Indicator	Interpretive question
ADHD symptoms	Validated scale plus one target behavior	Did attention or inhibition change across settings?
Anxiety	Presentation-specific scale; avoidance, reassurance, or panic	Did threat or avoidance change apart from productivity?
Function	Tasks begun, deadlines met, valued situations entered	Is daily life more workable in ways the person values?
Sleep and adverse effects	Sleep timing and quality; appetite, activation, cardiovascular effects	Could treatment burden explain the change?
Fit	Support use and between-session practice	What explains nonuse: memory, initiation, threat, burden, or preference?

XII. LIMITATIONS OF THE EVIDENCE

Evidence is substantially stronger for treating core ADHD symptoms or individual anxiety disorders than for choosing

integrated treatment sequences in adults with both. Comorbidity is often excluded, treated as a broad moderator, or relegated to a secondary outcome. Trials are usually brief relative to the lifespan course of ADHD and the recurrent course of anxiety. Functional recovery, adverse effects, treatment burden, and patient-prioritized outcomes receive less attention than symptom scores. The parallel-timeline and episode-sequence framework proposed here is therefore a clinical synthesis, not a validated diagnostic instrument or treatment package.

The 2025 adult ADHD network meta-analysis offers a broad but cautious picture: medication effects on core symptoms were more consistent across raters than nonpharmacological effects; certainty varied; improvement in quality of life was not established; and long-term evidence remained sparse (Ostinelli et al., 2025). These findings do not invalidate psychotherapy or multimodal care. They limit the claims that can be made and show the need for longer trials with credible controls and outcomes beyond clinician-rated symptoms.

Persistence across development is also more variable than a simple chronic-versus-remitted distinction suggests. Longitudinal estimates change materially with the definitions and thresholds used (Sibley et al., 2017). Childhood history should therefore be reconstructed carefully and current impairment assessed directly. Neither a childhood label nor a period of apparent remission removes the need to understand the present pattern.

Future studies should recruit comorbid samples deliberately, report anxiety diagnoses separately, compare treatment order and interaction, and follow functioning and harms over longer periods. They should include groups often underrepresented in specialty trials and distinguish symptom improvement from the practical capacity to organize, participate, rest, and pursue valued activities despite uncertainty.

XIII. CONCLUSION

Diagnostic value lies in the pattern and context of symptoms, not in their labels alone. Concentration difficulty, procrastination, restlessness, and overpreparation become informative only when their developmental course, triggers, function, and consequences are established. Parallel timelines clarify onset and course; episode-sequence formulation shows how the processes interact in the present.

Treatment order should be determined by risk and obstruction rather than by a fixed hierarchy of diagnoses. Integrated care may be staged: select a clear early priority, reduce the ways in which the second condition interferes with treatment, and monitor attention, anxiety, sleep, adverse effects, function, and burden separately. Medication effects on anxiety are variable, and psychotherapy adaptations should

reduce executive load without diluting the active mechanism of the anxiety treatment.

Diagnostic differentiation and therapeutic integration are complementary. A rigorous formulation replaces moral judgments with observable processes, recognizes the anxiety that can follow years of disorganization, and resists attributing every fear to ADHD. The practical aim is to distinguish the conditions closely enough to choose effective interventions while coordinating care around the life in which both are expressed.

XIV. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and has published on Communication-Focused Therapy (CFT). This article does not present CFT as a substitute for established assessment or evidence-based treatment. No other conflicts of interest were reported.

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