

Adult ADHD or Anxiety? Getting It Right

An online course

Clary Tepper, Ph.D.

Adult ADHD or Anxiety? Getting It Right

An online course

Clary Tepper, Ph.D.

WWW.CLARYTEPPERPHD.COM

01	Cover Page
02	Table of Contents
03	Welcome to this Course
04	ADHD & Anxiety: The Overlap Can Be Deceptive
05	The Comorbidity Question
06	Beyond the Overlap
07	Gender and Cultural Considerations
08	When Anxiety Hides ADHD
09	The Neurobiology of ADHD and Anxiety
10	Restlessness Versus Agitation
11	Distracted Minds
12	Inside the Insomnia
13	Emotional Dysregulation
14	Time Blindness
15	Beyond Procrastination: Task Paralysis

16	Verbal Impulsivity
17	Masking in ADHD
18	Screening and Assessment Tools Part 1
19	Screening and Assessment Tools Part 2
20	Screening and Assessment Tools Part 3
21	Screening and Assessment Tools Part 4
22	Distracted Minds
23	Cognitive and Emotional Differences
24	Differential Questions to Ask
25	Clinical Red Flags
26	Treatment Implications
27	Developmental History
28	Closing Reflections
29	Final Page
30	References

Adult ADHD or Anxiety? Getting It Right

Welcome to this Online Course

Course Description

Most of us have sat across from adult clients who seem anxious—distracted, overwhelmed, emotionally reactive—yet something doesn't quite add up. Maybe they've tried therapy, meds, or mindfulness, but the same patterns keep coming back, and you're starting to wonder: Is this really anxiety, or is it something else? This course is for healthcare clinicians who want to get better at telling the difference between adult ADHD and anxiety. We'll break down how these two often look alike from the outside, but come from very different internal drivers, and why that matters when it comes to getting the diagnosis and treatment right.

What You'll Learn

- How executive dysfunction and emotional reactivity in ADHD are frequently mistaken for anxiety
- The difference between task avoidance and anticipatory fear (and why it matters for treatment)
- What time blindness, verbal impulsivity, and task paralysis reveal about underlying neurocognitive patterns
- How “masking,” compensatory strategies, and strong verbal skills can obscure ADHD, especially in women and BIPOC clients
- What "poor concentration" actually means in ADHD vs. anxiety, and how to ask the right clinical questions
- How downtime triggers painful under-stimulation and restlessness in ADHD, versus relief or rumination in anxiety
- How to use tools like the GAD-7, CAARS, CPT-3, DIVA-5, BRIEF-A, and WFIRS more effectively (and how collateral info can help)

ADHD & Anxiety: The Overlap Can Be Deceptive

Shared Struggles

Clients with ADHD and anxiety often present with strikingly similar symptoms:

- Difficulty sustaining attention or staying focused on tasks
- Avoidance of responsibilities or goals, despite intentions to follow through
- Heightened emotional responses in day-to-day situations
- Trouble maintaining routines or meeting daily demands

These symptoms can look nearly identical on the surface, but what's driving them can be very different.

Different Roots of Those Shared Struggles

Inattention

- ADHD: Attention fluctuates with interest and stimulation. Tasks lacking novelty or urgency don't tend to hold attention. This explains why high-achieving clients may still struggle with routine demands.
- Anxiety: Focus is disrupted by internal noise. Persistent worry, intrusive thoughts, and a constant search for what might go wrong. In these moments, attention isn't absent, it's preoccupied.

Avoidance

- ADHD: Tasks are avoided due to executive dysfunction, forgetfulness, or difficulty initiating action.
- Anxiety: Tasks are avoided because of anticipatory fear, perfectionism, or fear of failure.

Emotional Profile

- ADHD: Emotions tend to come on fast and hit hard, especially in moments of frustration, overstimulation, or perceived criticism.
- Anxiety: The emotional tone is often steady but tense, shaped by ongoing worry, apprehension, and a sense of internal pressure.

Patterns of Behavior

- ADHD: You'll often see chronic disorganization, forgotten tasks, or trouble sticking to routines, especially when external structure is low.
- Anxiety: On the surface, things may look organized or tightly managed, and underneath, there may be fear, tension, or perfectionism that gets in the way of finishing things.

Why It Matters Clinically

- When we treat what we see instead of understanding what's underneath, we risk missing the mark.
- Superficially-similar symptoms often stem from very different roots—and those differences should shape how we diagnose, treat, and support our clients.

The Comorbidity Question

How common is the overlap in ADHD and anxiety?

- Estimates suggest that 60–80% of adults with ADHD also meet diagnostic criteria for an anxiety disorder. However, this rate may not reflect the full clinical picture. Because ADHD symptoms, like restlessness, poor concentration, and sleep disturbance, often resemble anxiety, many adults are first diagnosed with an anxiety disorder. In some cases, anxiety is the correct diagnosis. In others, it may be a misinterpretation of symptoms that are actually due to underlying ADHD.
- Once ADHD is recognized later in life, it's not always clear whether the anxiety is a true comorbid condition or a secondary response to years of unmanaged ADHD-related challenges, like academic underachievement, disorganization, or social strain.
- This diagnostic uncertainty is especially common among high-functioning individuals and women, who may compensate in ways that obscure ADHD symptoms. As a result, our estimated comorbidity rates may not be accurate.

Why ADHD and Anxiety Often Co-Occur

- ADHD and anxiety frequently overlap both because of shared neurobiology and lived experience. ADHD involves underactivity in brain regions that regulate attention and emotion (e.g., prefrontal cortex, dopamine/norepinephrine systems), while anxiety is driven by overactivation in the amygdala and HPA axis. These systems interact, making co-occurrence common.
- Psychologically, repeated struggles with organization, deadlines, or social feedback often lead to chronic worry or anticipatory fear. This secondary anxiety can further impair executive function, creating a feedback loop where anxiety and ADHD reinforce one another.
- Effective treatment requires understanding this dynamic and how these conditions interact.

Beyond the Overlap: What Looks Like Anxiety May Not Be Anxiety

Many core symptoms, like distractibility, restlessness, irritability, sleep issues, appear in both ADHD and anxiety. But surface similarity isn't the same as comorbidity.

Inattention and focus:

- ADHD: Inattention stems from executive dysfunction, leading to problems directing and sustaining focus.
- Anxiety: Inattention is driven by intrusive worry or rumination, both of which are driven by fear. Worry hijacks attention and keeps the mind preoccupied.

Misdiagnosing ADHD as anxiety is especially common in women, BIPOC clients, and high-functioning adults, often inflating comorbidity rates or delaying accurate diagnosis. For clients from cultural backgrounds that emphasize emotional restraint and discourage disruptive behavior, hyperactivity may never be outwardly expressed. Instead, ADHD may show up as internal restlessness, chronic disorganization, or mental fatigue, subtler patterns that are frequently misinterpreted as anxiety, particularly when clinicians are looking for more externalizing presentations.

Anxiety can be secondary to unrecognized ADHD:

- Chronic overwhelm and failure can both lead to reactive anxiety, which is different than a primary anxiety disorder.
- CBT for anxiety may backfire in clients with ADHD when it relies on tools (e.g., homework, thought logs) that require strong executive skills.

Standard screeners miss the difference:

- Tools like the GAD-7 capture overt worry but overlook executive dysfunction, meaning a client with ADHD-related overwhelm may score low despite significant impairment.
- Conversely, ADHD measures like the CAARS may miss internalized anxiety or the impact of chronic masking, especially in high-functioning adults. Without clinical context, these tools risk misclassifying or underestimating symptoms.

Why it matters:

- Accurate differentiation means more effective treatment, and prevents years of invalidation.

Gender and Cultural Considerations in ADHD Diagnosis

ADHD Research Has Historically Been Male-Centric

Decades of research and diagnostic tools were developed primarily through studies of hyperactive boys.

- **Presentation Differences**

- Boys tend to display externalizing behaviors such as impulsivity and high energy.
- Girls and women often present with inattention, emotional sensitivity, and compensatory behaviors that mask ADHD.

- **Diagnostic Gaps in Women**

- Many women aren't diagnosed until adulthood, after years of being misdiagnosed with anxiety or other mood issues.
- These internalized patterns and masking strategies can hide ADHD from traditional assessments.

- **Cultural & Referral Biases**

- Societal and cultural norms often discourage overt ADHD behaviors, especially in girls and BIPOC individuals, leading them to suppress symptoms.
- This means they're less likely to be referred for evaluation, and more likely to be labeled "anxious" or "moody" instead.

Clinical Takeaway

To avoid missed diagnoses, we need to use multiple assessment methods, collateral reports, functional measures, and specific questions about masking, compensation, and emotional struggles.

When Anxiety Hides ADHD

Painfully common scenario:

A client seeks help for anxiety, complaining about chronic worry, perfectionism, burnout, and their underlying ADHD symptoms (e.g., task initiation lag, distractibility, time blindness) are chalked up to anxiety or personality traits. ADHD remains undetected until coping strategies collapse under real-world pressure such as job loss, parenting burnout, academic strain.

What drives the delay?

- Strong verbal skills and structured environments can quietly compensate for the struggles seen in ADHD.
- Anxiety tends to appear earlier and causes more people to seek help.
- Clinicians often treat the obvious anxiety and never circle back to ADHD.

The clinical impact:

- The average delay from onset to official diagnosis is around 17 years
- Treating anxiety only leaves the root issue unaddressed and reduces treatment effectiveness.

The Neurobiology of ADHD and Anxiety: An Evolving Field

While this course won't go deep into brain imaging or neuroscience, it's worth noting that ADHD and anxiety are now widely understood to be separate conditions not just in how they present, but in how the brain processes them.

What We Know About ADHD

- ADHD is linked to disrupted dopamine and norepinephrine signaling.
- These disruptions affect brain areas responsible for attention, motivation, and self-regulation, particularly the prefrontal cortex, basal ganglia, and cerebellum.
- Studies also show that the brain networks involved in shifting focus and staying organized, like the default mode and frontoparietal networks, function less consistently in people with ADHD.

What We Know About Anxiety

- Anxiety disorders involve heightened activity in the brain's fear and threat-detection systems.
- The amygdala plays a central role, along with the HPA axis, which governs the stress response.
- People with anxiety show stronger and more persistent activation in these areas, along with reduced top-down regulation from the prefrontal cortex.
- Newer research has also found that different brain circuits are involved in brief vs. prolonged anxiety states.

Key Distinction

- ADHD involves underactivation or poor regulation in brain systems tied to attention and executive function.
- Anxiety is marked by overactivation in fear circuits and stress-response systems.

Restlessness (ADHD) Versus Agitation (Anxiety)

ADHD Restlessness--What Fuels It:

Restlessness in ADHD usually comes from under-arousal and executive control issues, not emotional stress. Individuals often need movement or mental activity to regulate their focus and alertness.

Stimming and fidgeting:

Many clients with ADHD naturally tap their feet, play with pens, or use fidget tools, not because they're upset, but to stay attentive, calm sensory input, or manage emotions. These behaviors tend to be rhythmic, intentional, and calming, and are helpful for regulating focus.

How it shows up:

- Are less prevalent when the person is engaged in a stimulating task.
- May not be outwardly noticeable. Clients might say they feel a "buzz" inside without moving much.
- Occurs consistently across different settings and moments and are tied to the person's internal state, not external stress.

Anxiety or Mood-Driven Agitation: What Fuels It:

This kind of restlessness stems from emotional overload (like panic, anxiety, or inner tension) which spill over into physical movements. It isn't used to regulate focus; it's a symptom of distress.

Typical behavior:

You might see pacing, hand-wringing, or tapping that's not soothing, it's purposeless. Clients often report feeling like they're "crawling out of their skin" or "can't sit still."

How it shows up:

- Appears during moments of emotional escalation: panic attacks, depressive agitation, manic episodes
- Often tied to pressured speech, irritability, or slowed thinking
- Duration and intensity fluctuate with emotional state, not consistent over time

Clinical Takeaway: Movement Does Not Always Signal Anxiety

- In ADHD, it's often a functional strategy, it's a way to self-regulate and help focus.
- In anxiety and mood disorders, it's not about regulation, it is an expression of emotional overflow and distress.

Distracted Minds: ADHD vs. Anxiety

ADHD: When Focus Fades, Not Willpower or Motivation

- Struggles with concentration come from challenges in executive functioning, like working memory delays, difficulty staying on task, and limited inhibition.
- Focus shifts depending on how engaging or stimulating a task is, not because of lack of motivation.
- Difficulties are most pronounced during unstructured or repetitive tasks, or where stimulation is low.

Anxiety: When Thoughts Take Over and Disrupt Focus

- Poor focus is a consequence of mental overload, clients are often consumed by worry, fear, or rumination.
- Their attention becomes hijacked by future-oriented, “what-if” thinking or internal threat monitoring.
- What looks like distractibility is really emotional hyperfocus, not a failure of motivation or energy.

Clinical Tip: Ask the Right Question

Instead of “Can you focus?”, try: “What’s happening in your mind when your focus slips?”

• **ADHD Responses:**

- “I sit down to do it, but my mind just skips around.”
- “I open the document, then somehow I’m answering emails or reorganizing files.”
- “I totally forget what I was supposed to be doing, even if I care about it.”

• **Anxiety Response:**

- “I’m going over every possible mistake I might make.”
- “I start working but then I keep replaying that conversation from earlier.”
- “My brain keeps jumping ahead to what could go wrong if I don’t get this perfect.”

Inside the Insomnia: Anxiety Loops or ADHD Delay Patterns?

ADHD-Related Sleep Issues

- Often rooted in time blindness: clients underestimate how long daytime tasks will take, pushing back bedtime.
- The ADHD brain may interpret the lack of external structure at night as “free time,” leading to late-night scrolling, gaming, or creative bursts.
- You might see what’s called *revenge bedtime procrastination*, where clients say, “This is the only time I have for myself, and I’m not giving it up, even if I pay for it tomorrow.”
- Sleep disruption isn’t typically due to worry or rumination, it’s more often tied to inconsistent routines and under-arousal, so clients don’t feel tired at a typical bedtime.
- Hyperfocus can also interfere with sleep. Clients may lose track of time while deeply engaged in a task, only realizing how late it is hours later.

Anxiety-Driven Insomnia

- Sleep gets hijacked by the mind: rumination, hyperarousal, and “what if” loops interfere with falling asleep.
- The brain races, the heart races, cortisol rises, and your client may say, “I just can’t shut my brain off.”
- Sleep is fragmented or delayed by persistent worry, rather than distractibility, poor time tracking, or hyperfocus.

Clinical Tip

When asking about a client’s sleep:

“Do you stay up late looking for stimulation, or do you lie awake because your mind won’t quiet down?”

- If it's unstructured delays, hyperfocus, or thrill-chasing, ADHD is likely.
- If it's racing thoughts and fear, anxiety is the more probable culprit.

Emotional Dysregulation: Snap Reactions vs. Sustained Worry

ADHD-Related Emotional Dysregulation

- Clients often experience sudden, intense emotional outbursts that are both short-lived and reactive.
- These flare-ups are frequently triggered by frustration, rejection sensitivity, or sensory overload.
- Neurobiologically, they stem from poor inhibitory control and weak regulation between the prefrontal cortex and amygdala.

Anxiety-Related Emotional Dysregulation

- Emotions tend to be sustained and anticipatory, not momentary.
- They're often internally focused, driven by a narrative of fear, worry, or inadequacy.
- This form of dysregulation involves ongoing vigilance rather than brief reactions.

Clinical Tip

- If a client says, "I go from 0 to 100 instantly," ADHD is more likely.
- If they say, "I can't stop worrying about how I felt yesterday," consider anxiety.

Time Blindness in ADHD: A Hidden Executive Deficit

Time Blindness in ADHD: A Faulty Internal Clock

What It Is

Time blindness refers to the tendency to consistently underestimate how long things will take, leading to missed appointments or frantic last-minute work. It's that moment when someone realizes there's only 10 minutes left despite thinking they had an hour.

Why It Happens

It isn't about laziness, it reflects underlying issues in the prefrontal cortex, especially the dorsolateral region, which governs executive functions like time awareness and planning. In ADHD, this "internal clock" doesn't provide reliable cues, resulting in executive disruptions even when clients are genuinely trying to stay on track.

How It Shows Up in Real Life

- A client says, "I thought I had another hour, but then it's suddenly ten minutes to go."
- You'll see this most clearly in unstructured or self-directed tasks, where there isn't natural external timing (like school bells or meeting schedules).

Clinical Use

- Understanding time blindness helps differentiate ADHD from simple disorganization or from anxiety-driven delays. Approach it as a neurological tendency, not a character flaw.

Beyond Procrastination: Task Paralysis in ADHD

Stuck at the Start: Understanding Task Paralysis in ADHD

Task Paralysis

This isn't about indecision, it's executive gridlock. The client wants to start a task, but something in the brain just stalls. The prefrontal cortex struggles to turn intention into action, and dopamine reward signals don't fire off until momentum builds.

“Irrational” Procrastination

It's not just avoidance, it's boredom sensitivity. Mundane, repetitive tasks don't engage the ADHD brain, so the person dreads the process of getting starting. That hesitation triggers pressure, guilt, and eventually a loop of stress-fueled delays.

Clinical Clues

- Clients often sound fed up with themselves:
 - “I know I need to do it, but I just can't get going, even though I hate putting it off.”
- It's persistent and unpredictable—daily and unrelated to fear—unlike anxiety-based procrastination, which tends to be task-specific and tied to worry.

Why It Matters

Recognizing task paralysis as an executive function issue helps us choose the right tools. We move away from fear-based interventions and toward activation strategies like breaking tasks into micro-steps, building in novelty, or using reward-linked prompts.

Verbal Impulsivity in ADHD: More Than Just Talking Too Much

Verbal Impulsivity in ADHD

Verbal impulsivity occurs when someone struggles to pause before speaking, leading to behaviors like:

- Blurting out answers before questions are completed
- Frequently interrupting others
- Abruptly changing topics
- Dominating conversations, especially when something is emotionally engaging or stimulating

These aren't always social missteps or anxiety. They often come from an inability to inhibit speech and poor self-monitoring rooted in ADHD.

What's Happening in the Brain

This pattern is tied to:

- Prefrontal cortex weakness: reduced top-down control over speech
- Basal ganglia and anterior cingulate: struggling to suppress impulses mid-conversation
- Dopamine disruption: difficulty gauging when to pause and reflect before speaking

Why It Matters (Hint: It Can Look Like Anxiety)

Verbal impulsivity may masquerade as anxiety-based overthinking or rehearsal, but the reasons are different. In ADHD, it's often about memory and impulse, not fear.

Clinical Clues

- "If I don't say it now, I'll forget it."
 - → This points to fear of forgetting, not social anxiety.
- "I rehearse conversations in my head, not because I'm nervous, but so I don't lose my train of thought."
 - → Indicates memory-driven self-regulation rather than rehearsal caused by anxiety.
- "I share too much, then feel embarrassed, but I couldn't stop myself in the moment."
 - → Shows impulsive speech control, not performance anxiety.

Masking in ADHD: The Hidden Cost of Passing as Neurotypical

What Clinicians Should Know

Masking in ADHD refers to the (often unconscious) process of suppressing or compensating for symptoms in order to appear more regulated, focused, or socially appropriate. It's not about deception, it's a coping strategy, developed over time, to meet neurotypical expectations in school, work, and relationships.

Why It Matters: Cognitive and Emotional Fatigue

These compensatory strategies, whether obsessive note-taking, mental rehearsal, or hypervigilant self-monitoring, require sustained executive effort. Over time, this leads to a unique kind of burnout that can easily be misread as anxiety. But unlike social anxiety, the driver isn't fear of judgment, it's the need to stay in control of internal chaos.

Clinical Indicators That Suggest Masking

- "By the end of the day, I'm totally wiped out, even if I didn't do much."
 - → Suggests chronic mental strain from internal regulation efforts, not physical exertion.
- "I go over what I'm going to say before meetings so I don't sound disorganized."
 - → Often misinterpreted as anxiety-related perfectionism, but more accurately reflects working memory compensation.
- "It feels like it takes everything I've got just to seem like I'm functioning."
 - → Points to the invisible executive load clients carry to maintain the appearance of stability.

Why This Distinction Matters

These patterns can easily be mistaken for anxiety, especially when external behavior appears controlled. But the underlying mechanism is different, and so is the treatment. Recognizing masking allows us to validate the client's internal effort and pivot toward interventions that reduce cognitive load, rather than adding more demands for control.

Screening and Assessment Tools: What Clinicians Need to Know

Part 1: ADHD Tools

Important Note: There's No One Test for ADHD

- ADHD diagnosis isn't based on a single screener or test.
- It requires a multi-method approach: interviews, rating scales, history, and behavioral data.
- Symptoms must be seen across contexts and over time.
- Rating tools (like CAARS, DIVA-5, WFIRS) help, but can't stand alone.
- Always assess functional impairment, not just traits.
- Rule out lookalikes like anxiety, trauma, or burnout.

CAARS (Conners Adult ADHD Rating Scale)

Strengths:

- Offers a quick, reliable self-report of ADHD-related symptoms.

Limitations:

- Struggles to separate ADHD from anxiety. Restlessness and poor focus can inflate scores.

Clinical Tip:

- Focus on the inattentive subscale, and always validate with information from partners, colleagues, or family.

DIVA-5 (Diagnostic Interview for Adult ADHD)

Strengths:

- Structured around DSM-5 criteria, and shows solid reliability and validity.

Limitations:

- It doesn't assess anxiety, so if you rely on it alone, co-occurring anxiety can be missed.

Clinical Tip:

- Always include an anxiety measure to capture the full clinical picture.

CPT-3 (Continuous Performance Test)

Strengths:

- Provides an objective look at attention, reaction time, and impulsivity.

Limitations:

- Anxiety, especially worry or stress, can sabotage performance and mimic ADHD on the test.

Clinical Tip:

- If CPT-3 results are concerning, pair them with behavioral observations and history to see if inattention fits ADHD or reflects anxiety.

Clinical Note: Although these measures look specifically at ADHD symptoms, they can not be used in isolation to diagnose ADHD.

Screening and Assessment Tools: What Clinicians Need to Know

Part 2: Anxiety Tools

GAD-7 (Generalized Anxiety Disorder 7-Item Scale)

Strengths:

- Quick to administer and interpret
- Well-validated for detecting generalized anxiety in primary care and mental health settings

Limitations:

- Focuses solely on anxiety symptoms: doesn't assess executive function, time blindness, or hyperactivity
- ADHD symptoms like distractibility or racing thoughts may be misunderstood as anxiety
- A high score could reflect ADHD-driven stress, not just anxiety

Clinical Tip:

If GAD-7 is elevated, add an ADHD screener or ask about time perception and task initiation to clarify.

BAI (Beck Anxiety Inventory)

Strengths:

- Measures physical symptoms of anxiety such as heart palpitations, sweating, and dizziness
- Psychometrically strong and useful for identifying physiological anxiety

Limitations:

- ADHD-related restlessness and underarousal can mimic physical anxiety symptoms, inflating scores
- Doesn't differentiate between anxiety-driven physical symptoms and ADHD-driven physiological arousal, which is a baseline state of internal restlessness and heightened activation that's not fueled by worry, but by dysregulated alertness and a need for stimulation.

Clinical Tip:

When BAI responses are high, explore situational triggers. Ask whether symptoms follow worry or are chronic background states tied to ADHD.

Additional Considerations

- GAD-7 and BAI both miss core ADHD features, like time management issues or executive paralysis
- If scores are high, but your clinical impression includes impulsivity or masking behaviors, consider dual screening or follow-up assessments (e.g., CAARS, BRIEF-A)

Why This Matters

- Relying on anxiety tools without considering ADHD can lead to the wrong treatment, unnecessary medication trials, and lingering impairment.
- A comprehensive assessment covers both paths—or at least flags when one might be hiding behind the other.

Screening and Assessment Tools: What Clinicians Need to Know

Part 3: Executive Function Scales

Executive Function and Functional Scales: BRIEF-A & WFIRS

BRIEF-A (Behavior Rating Inventory of Executive Function – Adult)

Strengths:

- Pinpoints real-world executive challenges, like planning, organization, inhibition, and working memory.

Limitations:

- Some behaviors, like overplanning or rigid routines, appear in both ADHD and anxiety; careful interpretation is needed to determine if it's compensatory strategy or anxiety-driven.

Clinical Tip:

- Look at the pattern: are these behaviors sporadic and task-based (suggestive of ADHD), or more chronic and linked to worry? Always cross-check with other sources.

WFIRS (Weiss Functional Impairment Rating Scale)

Strengths:

- Measures functional difficulties across multiple life areas (work, family, social, self-care), providing a picture of the real-world impact of executive dysfunction.
- Especially useful when used alongside symptom checklists to differentiate severity and patterns of impairment.

Limitations:

- It's a self-report tool, so responses may be shaped by mood states, situational stress, or limited self-awareness—especially in clients who've masked for years.

Clinical Tip:

- If WFIRS scores suggest impairment, follow up with collateral reports or observable behavior samples to clarify if ADHD is the driving factor.

Executive Function Scales: Why They Matter

- They offer a deeper view of how daily executive challenges affect real life.
- Alone, they can't pinpoint ADHD; pairing them with symptom scales, collateral input, and clinical judgment is essential.

Screening and Assessment Tools: What Clinicians Need to Know

Part 4: Collateral Interviews

Seeing the Full Picture: Why Collateral Interviews Matter

Why Go Beyond Self-Report?

Self-report scales and structured assessments provide valuable data, but they're limited. Clients may unintentionally downplay or misinterpret symptoms because of poor insight, emotional state, or well-honed masking strategies. That's why collateral interviews such as speaking with partners, close friends, coworkers, or family, are critical.

How Collateral Data Helps

- Highlights observable behavior across settings: impulsivity, inattention, mood fluctuations, and inconsistent performance.
- Uncovers hidden patterns: informants often notice details the client misses or misattributes, like frequent task avoidance labeled as anxiety or low motivation.
- Adds context for differential diagnosis: a behavior seen as anxious in one setting may clearly be executive failure in another.

Summary: No Single Test Is Comprehensive Enough To Be Diagnostic

Use multiple tools

- ADHD checklists and structured interviews (CAARS, DIVA-5, CPT-3, BRIEF-A)
- Anxiety measures (GAD-7, BAI)
- Measures of daily functioning (WFIRS)

Layer in collateral insights

- Observe how symptoms play out in everyday life
- Compare self-reports to others' observations

Synthesize thoughtfully

- No score tells the whole story
- Integrate data to differentiate ADHD from anxiety—or identify their co-presence

Distracted Minds: ADHD vs. Anxiety

ADHD: Context-Dependent Focus

- Attention drops off in low-stimulation or unstructured settings
- Driven by executive dysfunction, not lack of effort
- Most noticeable with routine or repetitive tasks

Anxiety: Focus Hijacked by Worry

- Attention is consumed by intrusive thoughts and threat monitoring
- Disrupted by internal noise, not external boredom
- Often misread as poor motivation or distractibility

Clinical Tip: What's the Question That Reveals the Difference?

Ask "What's happening in your mind when your focus drifts?" instead of simply "Can you focus?"

- ADHD replies might include:
 - "I sit down but my mind skips between ideas."
 - "I open the report, then I'm suddenly doing emails or organizing files."
 - "I just forget what I was doing, even if I care about it."
- Anxiety responses may sound like:
 - "I replay every possible mistake I could make."
 - "I can't stop revisiting that awkward conversation."
 - "My brain jumps ahead, worrying about what could go wrong if it's not perfect."

Why This Distinction Matters

These look-alike behaviors have very different roots, and therefore, call for different treatment paths. Recognizing whether focus is fading or being commandeered helps us choose interventions that truly support the client's brain.

Table of Cognitive & Emotional Differences

Feature	Adult ADHD	Anxiety Disorders
Attention	Variable, context-sensitive	Sustained but with an anxious focus that can result in impairment
Memory	Working memory deficits	Intact but biased by worry
Emotion	Rapid shifts, rejection sensitivity	Chronic worry, anticipatory fear
Behavior	Disorganized, impulsive	Avoidant, perfectionistic

Differential Questions to Ask

Ask: “What happens when structure disappears?”

- ADHD: Needs structure to stay on task—but may ignore the structure or forget it.
- Anxiety: Tends to feel safer with routines, even if they’re rigid.

Ask: “Do you freeze because you don’t know what to do—or because you can’t get started even when it is?”

- ADHD: Struggles to get started on the task, even when they know what to do.
- Anxiety: May freeze when faced with uncertainty or fear of error.

Ask: “Is boredom stressful or calming?”

- ADHD: Boredom feels unbearable—leads to restlessness or stimulation-seeking.
- Anxiety: Stillness may ease arousal—or invite rumination.

Ask: “How do you handle interruptions or shifting gears?”

- ADHD-type response: “I lose the thread and bounce between things.”
- Anxiety-based response: “I feel anxious unless I finish what I started.”

Clinical Takeaway:

Use open-ended, targeted questions to distinguish whether the client is dysregulated by understimulation (ADHD) or overactivation (anxiety). Subtle distinctions in how tasks are approached can reveal core diagnostic differences.

Clinical Red Flags for Missed ADHD Diagnosis

Clues You're Treating the Wrong Diagnosis: When ADHD Hides Behind Anxiety

Stalled Progress Despite "Trying Everything"

- Clients may report long therapy histories with little relief: multiple therapists, modalities, or medications targeting anxiety or trauma, with no lasting change.
 - → Consider: Has executive dysfunction been overlooked?

The Abandoned Trail

- Their environment or narrative reveals a pattern: A trail of unfinished hobbies, online courses, planners, unread books.
 - → Not flakiness, but a cycle of novelty-seeking, paralysis, and follow-through difficulty rooted in ADHD.

Anxiety Feels Secondary, Not Core

- Clients may say, "I'm anxious because I always lose track of things or miss deadlines."
 - → That anxiety may be reactive, stemming from ADHD-driven forgetfulness, time-blindness, disorganization, or executive function shutdown.

Well-Spoken on Anxiety, But Blind to ADHD

- Clients can name every anxious thought but can't explain why they're always late or scattered.
 - → Strong insight into worry, but little understanding of executive function symptoms or how to work to manage them.

Shame That Feels Bigger Than the Mistake

- Minor missteps trigger emotional spirals: "What's wrong with me?"
 - → This isn't just self-criticism, it often reflects years of undiagnosed ADHD masked by high achievement or perfectionism.

Emotional Dysregulation That Won't Budge

- When irritability, overwhelm, or rejection sensitivity don't respond to anxiety treatments, explore ADHD.
 - → These may be driven by frustration tolerance or cognitive overload, not just anxious hyperarousal.

Clinical Takeaway:

If treatment for anxiety feels like managing the fallout rather than solving the root cause, it's time to reassess. Executive dysfunction might be the missing piece.

Treatment Implications

Stimulants Aren't Always the Answer

- Stimulants can be life-changing for ADHD, but they're not a fit for everyone, especially clients whose anxiety is rooted in hyperarousal or fear.
 - → Side effects like jitteriness or increased heart rate can mimic or worsen anxiety symptoms.

Standard CBT Can Miss the Mark

- Traditional CBT often leans on structured homework, future planning, and cognitive tracking, tasks that assume intact executive functioning.
 - → For clients with ADHD, these demands may lead to avoidance or shame, not helpful change.
 - → ADHD-informed CBT means smaller steps, visual cues, external accountability, and behavioral tools, not just cognitive ones.

Treat the Full Picture

- When ADHD and anxiety co-occur—as they often do—treating just one can destabilize the other.
 - → Stimulants might reveal masked social anxiety.
 - → Calming anxiety down may reveal executive dysfunction.
 - → Clients need help with both emotion regulation and task management.

Psychoeducation Builds Insight and Eases Shame

- Many clients carry a long history of self-blame: missed deadlines, failed routines, and/or strained relationships.
 - → Explaining ADHD as a neurodevelopmental condition can be a game-changer. ADHD is not a lack of effort or willpower.
 - → Language that validates and de-pathologizes a client's experience can help them reframe their struggles and re-engage in treatment.

Clinical Takeaway

There's no plug-and-play formula. Treatment needs to take into account the less-obvious or hidden symptoms your client is experiencing. (And you need to always consider how shame might be showing up in the room.)

Developmental History: Look for Clues

Inconsistent Performance: Not Always Poor Grades

- Many adults with ADHD don't report failing in school. In fact, they may have been strong students, especially in subjects they enjoyed or in highly structured classrooms. The real story is often quieter: racing to finish assignments at the last minute, daydreaming during lectures, or missing deadlines despite knowing the material.
- In contrast, anxiety tends to impact performance across subjects, driven by pervasive worry or fear of failure, not fluctuations in interest or attention.

“Smart But Lazy” Theme

- A common theme among undiagnosed ADHD adults is being labeled a “bright underachiever.” They were capable—sometimes gifted—but struggled to translate their potential into consistent output. This gap between ability and performance is often a hallmark of executive dysfunction.
- Meanwhile, kids with anxiety may underperform due to perfectionism or fear of being wrong, but often overcompensate with effort and preparation, particularly in areas where they feel pressure to succeed.

Were They Worried or Scattered?

- Anxiety in children tends to show up as frequent worry, reassurance-seeking, or stomachaches before school.
- ADHD, on the other hand, might have looked like being distractible, blurting in class, or forgetting to turn in homework. These behaviors are sometimes brushed off as “immaturity”—especially in girls or high-IQ children.
- A helpful clinical question: As a child, were they known for being a worrier, or as someone who was inconsistently engaged, couldn't sit still, stay focused, or finish what they started?

Coping Styles: Adaptive vs. Exhausting

- Anxious kids often try to stay ahead of their discomfort by becoming perfectionists or rule-followers. These strategies can mask distress and delay diagnosis.
- Kids with ADHD often use compensatory strategies, like cramming, relying on verbal strengths, or rigid routines, to manage overwhelm and mask executive difficulties.
 - These strategies may work early on, but tend to collapse when academic demands increase, or in adult life, when external structure fades.
- Understanding how they coped—not just how well—can reveal what was going on beneath the surface.

Closing Reflections: Rethinking What We Think We Know

Missing the Mark: When “Anxiety” Isn’t What It Seems

Too often, what looks like anxiety is actually something else entirely. We're learning that the comorbidity of ADHD and anxiety might not be as high as it appears. Why? Because many adults with ADHD—especially high-functioning women and BIPOC clients—are misdiagnosed. Their real struggle isn't just worry or fear; it's a lifetime of executive dysfunction that's been camouflaged by a raft of compensatory measures.

Yes, true comorbidity exists. But we need to ask:

How many clients with “treatment-resistant anxiety” are actually dealing with undiagnosed ADHD?

When someone says, “I’m constantly overwhelmed,” or “I can’t focus no matter how hard I try,” the default label is usually anxiety. But dig deeper, and the story often shifts, away from fear-based distress and toward a brain that’s been white-knuckling through life without the right kind of support.

Why It Matters Clinically

When ADHD is mislabeled as anxiety, clients get stuck in the wrong treatment path. Medication doesn't help. Therapy stalls. Shame builds.

But when we see the full picture— how executive dysfunction can mimic anxiety—we offer something better: clarity and treatment that actually fits.

This isn't about splitting diagnostic hairs. It's about finally naming what our clients have been feeling for years, and helping them move forward with tools that work.

Thank You

for reading

Clary Tepper, PhD

Clinical psychologist

www.clarytepperphd.com

Reference List, Page One

Appelbaum, M., Cooper, H., Kline, R. B., et al. (2018). Journal article reporting standards for quantitative research in psychology: The APA Publications and Communications Board Task Force Report. *American Psychologist*, 73(1), 3–25. <https://doi.org/10.1037/amp0000191>

Cash, T. F. (2009). Caveats in the proficient preparation of an APA-style research manuscript for publication. *Body Image*, 6(1), 1–6. <https://doi.org/10.1016/j.bodyim.2008.10.003>

Cuschieri, S., Grech, V., & Calleja, N. (2019). WASP (Write a Scientific Paper): The use of bibliographic management software. *Early Human Development*, 128, 118–119. <https://doi.org/10.1016/j.earlhumdev.2018.09.012>

Hamdi, N. R., Cutler, M. J., Hollon, S. D., et al. (2021). APA guidelines on evidence-based psychological practice in health care. American Psychological Association.

Levitt, H. M., Bamberg, M., Creswell, J. W., et al. (2018). Journal article reporting standards for qualitative primary, qualitative meta-analytic, and mixed methods research in psychology: The APA Publications and Communications Board Task Force Report. *American Psychologist*, 73(1), 26–46. <https://doi.org/10.1037/amp0000151>

Li, P., & Cunningham, K. (2005). The APA Style Converter: A web-based interface for converting articles to APA style for publication. *Behavior Research Methods*, 37(2), 219–223. <https://doi.org/10.3758/bf03192689>

Morse, G. G. (2009). Faculty application of the American Psychological Association style. *Journal of Nursing Education*, 48(10), 542–551. <https://doi.org/10.3928/01484834-20090610-10>

Peh, W. C., & Ng, K. H. (2009). Preparing the references. *Singapore Medical Journal*, 50(7), 659–661; quiz 662.

Russell, C. L., & Aud, M. A. (2002). Publication Manual of the American Psychological Association-5th Edition: A review of additions and changes in style requirements. *Nursing Research*, 51(5), 332–335. <https://doi.org/10.1097/00006199-200209000-00010>

Salvagno, G. L., Lippi, G., Montagnana, M., & Guidi, G. C. (2008). Standards of practice and uniformity in references style. *Clinical Chemistry and Laboratory Medicine*, 46(4), 437–438. <https://doi.org/10.1515/CCLM.2008.114>

Stevens, J. R., & Duque, J. F. (2019). Order matters: Alphabetizing in-text citations biases citation rates. *Psychonomic Bulletin & Review*, 26(3), 1020–1026. <https://doi.org/10.3758/s13423-018-1532-8>

Reference List, Page Two

Kooij, J. J. S., Bijnenga, D., Salerno, L., Jaeschke, R., Bitter, I., Balázs, J., ... & Asherson, P. (2019). Updated European Consensus Statement on diagnosis and treatment of adult ADHD. *European Psychiatry*, 56, 14–34. <https://doi.org/10.1016/j.eurpsy.2018.11.001>

Kroese, F. M., Evers, C., Adriaanse, M. A., & de Ridder, D. T. D. (2016). Bedtime procrastination: A self-regulation perspective on sleep insufficiency in the general population. *Journal of Health Psychology*, 21(5), 853–862. <https://doi.org/10.1177/1359105315571974>

Livingston, L. A., Shah, P., & Happé, F. (2019). Compensatory strategies below the surface in autism. *The Lancet Psychiatry*, 6(9), 766–777. [https://doi.org/10.1016/S2215-0366\(19\)30224-X](https://doi.org/10.1016/S2215-0366(19)30224-X)

Martel, M. M. (2009). Research review: A new perspective on attention-deficit/hyperactivity disorder: Emotion dysregulation and trait models. *Journal of Child Psychology and Psychiatry*, 50(9), 1042–1051. <https://doi.org/10.1111/j.1469-7610.2009.02105.x>

Maté, G. (2008). *Scattered minds: The origins and healing of attention deficit disorder*. Plume.

Müller, V., Mellor, D., & Piko, B. F. (2023). How to procrastinate productively with ADHD: A study of smartphone use and academic variables. *Journal of Attention Disorders*, 27(9), 951–959. <https://doi.org/10.1177/10870547231171724>

Palmer, C. A., & Alfano, C. A. (2017). Sleep and emotion regulation: An organizing, integrative review. *Sleep Medicine Reviews*, 31, 6–16. <https://doi.org/10.1016/j.smrv.2015.12.006>

Perugi, G., Frare, F., & Toni, C. (2001). Agitated depression: Clinical features and therapeutic approach. *Journal of Affective Disorders*, 67(1–3), 135–142. [https://doi.org/10.1016/S0165-0327\(01\)00477-5](https://doi.org/10.1016/S0165-0327(01)00477-5)

Quinn, P. O., & Madhoo, M. (2014). A review of attention-deficit/hyperactivity disorder in women and girls: Uncovering this hidden diagnosis. *The Primary Care Companion for CNS Disorders*, 16(3). <https://doi.org/10.4088/PCC.13r01596>

Ramos-Quiroga, J. A., et al. (2020). DIVA-5: Diagnostic Interview for ADHD in adults, reliability and validity. *Journal of Attention Disorders*. <https://doi.org/10.1177/1087054720930816>

Ramsay, J. R. (2010). *Cognitive Behavioral Therapy for Adult ADHD: An Integrative Psychosocial and Medical Approach*. Routledge.

Ramsay, J. R. (2020). *The adult ADHD toolbox: A guide to diagnosing and treating attention deficit hyperactivity disorder*. PESI Publishing.

Raymaker, D. M., Teo, A. R., Steckler, N. A., & Nicolaidis, C. (2020). “Having all of your internal resources exhausted beyond measure...”: Defining, measuring, and addressing autistic burnout. *Autism in Adulthood*, 2(2), 132–143. <https://doi.org/10.1089/aut.2019.0079>