A Closer Look at ADHD in Adults

Introduction

Many adults start to wonder about ADHD after years of struggling with attention, organisation, restlessness or emotional intensity — often in a way that has felt confusing, or like having to work much harder just to get by. For some, the question follows years of being treated for anxiety or low mood with limited benefit. For others it surfaces after recognising the same patterns in a child, or hearing someone describe an experience that feels strikingly familiar.

Coming across ADHD as an explanation can be a relief. It can make sense of long-standing patterns and lift some of the self-blame. It can also raise new questions — about identity, about treatment, and about what actually changes from here. I've written this to look at what ADHD is and isn't, what the evidence does and doesn't show, and how to think about next steps — along with practical things you can do now, whether or not you have a diagnosis or take medication. It is not intended to be exhaustive or a definitive guide. It is based on my own experience and reading of the evidence, and is what I would share if I had unlimited consultation time. Other clinicians and patients see some of these questions differently, and that there is more than one reasonable position – I offer this as my own view I have come to over time based on clinical experience. I always maintain that each person is the expert in the details of their own lives and how they relate to and understand their own experience.

Key Points

- ADHD is a description of a pattern of traits, not a disease with a known biological fault. The difficulties are real, and they can be substantial.
- A diagnosis can validate your experience and open doors to practical supports and sometimes medication.
- Support does not have to wait for an assessment. Many adjustments can help whether or not you have a diagnosis.
- Medication helps many people in the short term. The long-term picture is less certain, so review it regularly.
- In England the routes to assessment are the NHS, Right to Choose and private. If you are considering going private, ask your GP practice about shared care first.
- If you are struggling with low mood, anxiety or thoughts of harming yourself, seek help sooner (see the end of this guide).

What Is ADHD?

ADHD is a widely recognised diagnosis, used across the world, and the difficulties it describes can be substantial — affecting work, study, relationships, finances, driving and self-esteem. When trained clinicians use agreed criteria, they tend to agree on it.

What helps is to understand what kind of thing ADHD is. It is not a disease with an identifiable biological fault. There is no blood test, brain scan or genetic test that reliably correlates with the diagnosis. It is best understood as a description of a pattern — a cluster of traits and difficulties that tend to occur together and cause real problems in certain settings. Plenty of other conditions, such as migraine, work the same way: they are diagnosed from the pattern rather than from a test. That does not make the difficulties any less real.

What clinicians mean by ADHD in adults

In adults, ADHD is used to describe persistent patterns of difficulty with attention, organisation, impulsivity, restlessness or emotional reactivity that significantly interfere with daily life. These patterns are understood to begin in childhood, even if they were never recognised at the time, so an assessment looks at your developmental history as well as how things are now.

The traits involved — distractibility, high energy, novelty-seeking, emotional intensity, difficulty sticking with repetitive tasks — are not something a person simply has or does not have. They are spread right across the population, and everyone sits somewhere on each of them. What we label ADHD is a region towards one end of that range, where the traits are strong and persistent enough, and interfere enough with everyday demands, to cause real difficulty. A diagnosis is considered when that pattern is persistent, shows up across different parts of life, and significantly interferes with life — not simply because the traits are present. Where that threshold sits is a matter of clinical judgement against agreed guidelines.

What is known — and not known — about the biology

ADHD is often called a neurodevelopmental condition, and people talk about “different wiring” or “different kinds of brain.” There is something to this, but not in the way it is popularly presented, and it is important to be aware of what the studies do and don’t show. Research, including brain imaging and genetics, has found small average differences between groups of people with and without the diagnosis, in systems involved in attention, reward and impulse control. But these differences are small, overlap heavily with everyone else, and are not present in all those diagnosed.

It helps to remember that all brains differ. If you scanned everyone, you would find variation, simply because no two people are identical. When you select a group who share certain traits, finding some average differences is expected, and it does not amount to a biological test. Genetics works in a similar way: many genes each contribute a tiny effect, spread widely through the population, with no single “ADHD gene.” So biology clearly affects attention and behaviour, but it does not draw a clean line around ADHD or fully explain any one person’s experience. It is best understood as part of the context, not the whole story.

Why it can become more visible in adulthood

Many adults describe coping for years and then struggling more at a particular point. This usually does not mean ADHD has suddenly appeared. More often, the demands went up or the support structures were reduced. Childhood often supplies external structure — school timetables, reminders, supervision. Adult life asks you to plan, prioritise, manage time and money, and stay on top of things largely under your own steam.

Transitions such as university, a demanding job, parenthood, or the loss of a supportive routine can expose difficulties that were previously more easily dealt with. Stress, poor sleep and low mood also stretch attention and organisation thin, so things often feel worse when stressors are building up.

Attention in a distracting world

I think it's relevant to look at the world our attention now has to work in. Much of modern life is built around constant interruption: phones designed to pull focus, notifications competing for it, rapid switching between tasks, and streams of information that reward quick, shallow attention over slow, sustained effort. These environments fragment attention in everyone. Difficulty concentrating, restlessness and a scattered, overloaded feeling are extremely common — and they look a great deal like the difficulties we describe as ADHD.

The demands of the environment and a person's underlying traits interact. Attention regulation varies from one person to the next; for someone whose attention is already more sensitive to distraction or more drawn to novelty, a world engineered to fragment focus tends to amplify difficulties that might have been more manageable in a quieter, more structured setting. The same environment that mildly scatters one person can be genuinely disabling for another.

This means some of what can sometimes feel like personal difficulty is partly a mismatch between how your attention works and how the modern world is set up — this is where adjustments can come in. Altering your surroundings to protect attention, by reducing interruptions, building in structure, and making space for sustained focus, is a reasonable response to demands, and it tends to help whether or not you have a diagnosis.

It also helps explain why far more people are being recognised and assessed than in the past. As everyday demands on attention have grown, more people find the description fits them. And because the line between the usual range and a diagnosis is set by clinical judgement and context rather than a biological test, it is not fixed — it has moved downwards over time and sits differently depending on the setting and the support available. The boundary is blurred, can vary by assessment, and the same person might be judged over the line in one setting and within the usual range in another. What matters most is whether understanding the pattern helps you get the support and adjustments that make life more manageable.

Identity — a personal choice

For some people, ADHD becomes an important part of how they understand themselves, and a source of connection with others who share the experience. Others prefer to treat it as a useful description of certain patterns rather than a defining feature of who they are. There's no right or wrong way to relate to it, and what tends to matter to most people is that the diagnosis can help with validation and understanding of difficulties, and lead towards help and support to make life more manageable.

A description, not a separate force

It is completely natural to talk about "my ADHD," and most people do — it is a useful shorthand for patterns that often cause significant difficulty. There is a distinction though that is worth thinking through. ADHD is the name we as a culture currently give to a cluster of natural human traits that tend to occur together. The name dates from the later part of the 20th century; it first appeared in the psychiatric diagnosis manual, the DSM, in 1980, as attention deficit disorder. It is a description of those patterns — not a separate entity or force. The traits are there, and vary in intensity and functional impact depending on environment; the word is simply a label for them. That can sound like a fine distinction, but it is important in practice. When the label starts to feel like something with a will of its own — "my ADHD made me do that," or "I can't, because of my ADHD" — it can hand your sense of agency over to what was only ever a description. Difficulties can begin to feel fixed and beyond your control, and possibilities can close down without you noticing.

Seeing ADHD as a description rather than a driver does not make the difficulties any less real. It keeps your sense of agency in the picture. The patterns can be worked with, through structure, support, changes in the environment and, for some, medication; and you remain the person making your choices. I know that other clinicians and patients see this differently. I have found this framing useful, so I offer it for you to consider.

Getting an assessment

A diagnosis should follow a proper assessment by a suitably trained specialist. Questionnaires can be useful as a first screen, but they are not diagnostic on their own. A good assessment looks in detail at your current difficulties and at your developmental history — by definition the pattern starts in childhood, even if it wasn't named at the time — and, where possible, draws on someone who knew you growing up. It also weighs up other explanations, because anxiety, depression, trauma, poor sleep and chronic stress can all affect attention and often overlap. The aim is to understand the whole picture.

In England there are three main routes to an assessment. The standard NHS route, through your GP to a local service, is free, but waits are often long — frequently many months, and in some areas a few years. The NHS Right to Choose scheme lets you ask your GP to refer you to any NHS-approved provider in the country rather than only the local service; it is still NHS-funded and free to you, and is often quicker. Your GP can only turn this down if they do not

think an assessment is clinically warranted. A private assessment is usually the fastest, often within weeks, but you pay for it and the cost can be significant. (Right to Choose applies in England; elsewhere in the UK the options are the local NHS service or going privately.)

Services, waiting times and local policies change and vary by area, so check the current position with your GP practice or the NHS before you decide.

If you are diagnosed and start medication, the dose usually needs adjusting over a few weeks. After that, ongoing prescriptions can often be transferred to your GP under what is called a shared-care agreement. It is worth knowing in advance that not all GP practices accept shared care, particularly from private providers — if yours does not, you may need to keep getting prescriptions, and paying for them, through whoever assessed you. So if you are thinking of going private, it is sensible to ask your own GP practice beforehand whether they would take on shared care.

The quality of assessments varies between providers. Your GP or local NHS service will check that an assessment meets recognised standards before taking over prescribing, and a thorough assessment carried out in line with national (NICE) standards is less likely to run into problems later. If you are choosing a provider — privately or through Right to Choose — it is worth checking that they do a full assessment.

Diagnosis, support and treatment

An ADHD diagnosis can be helpful for some people. It can give a framework that makes sense of long-standing patterns, reduce shame or self-blame, support requests for workplace adjustments, and guide discussions about treatment. But a lot of practical support does not need a diagnosis — many people benefit from adjustments, strategies and support long before any formal assessment or treatment. It is worth holding these three things apart, because waiting for one need not hold up the others.

In much of medicine, a diagnosis is the discovery of an underlying cause, and naming that cause points to a treatment that corrects it. Type 1 diabetes is a clear example: the symptoms — thirst, tiredness, weight loss — turn out to be caused by a lack of insulin, and replacing the insulin corrects the problem. It is tempting to assume ADHD works the same way, and long waits can make it feel as though the diagnosis will be the moment everything is finally put right. But ADHD is not like that. We are not uncovering a hidden condition beneath the traits; we are choosing to apply a diagnostic label to a pattern of traits that is already there. That label can be genuinely useful — it can make sense of things, ease self-blame, open doors and guide support — but it is a description, not the discovery of something correctable underneath. Holding that in mind, and keeping expectations realistic, protects against pinning everything on a “cure,” since that framing doesn’t really fit what is going on.

Treatment aims to reduce the difficulties associated with the traits that contribute to a diagnosis of ADHD, and make daily life more manageable. For most people that means a

combination of practical strategies, changes to environment and routine, and, for some, medication.

Medication

Stimulants such as methylphenidate and lisdexamfetamine are usually offered first, with non-stimulant options such as atomoxetine or guanfacine where stimulants do not suit. They increase signalling of dopamine and noradrenaline in attention-related networks. Importantly, they are not correcting a known defect — they alter brain function in ways that can sharpen attention and reduce impulsivity in those who take them.

Short-term trials consistently show they reduce symptoms more than a placebo over weeks to months. The size of that effect is larger than for many psychiatric medicines, and for people who respond it can make a real difference, particularly with distractibility or getting started on tasks. Many people notice a difference fairly quickly. There is much less certainty about the long term. Good evidence for sustained benefit in the broader areas of life — relationships, job satisfaction, overall wellbeing — is more limited, and medication on its own does not reliably improve these. Large observational studies suggest that during the periods people take medication, certain risks such as accidents, self-harm or substance problems tend to be lower, although these studies cannot prove medication alone is the cause. For some people the benefits plateau, or side effects come to outweigh them.

Side effects are usually manageable but can include reduced appetite or weight loss, disturbed sleep, a faster heart rate or higher blood pressure, headaches and stomach upset. Some people also notice emotional effects — feeling flat or less themselves, more anxious or irritable, or low and tired as a dose wears off. These are not universal, but are worth recognising, monitoring and reviewing.

Before you start, your prescriber should check your blood pressure, pulse and weight, and ask about heart problems, including any family history of sudden heart-related death, as well as any history of high blood pressure, psychosis or substance misuse. Tell them about all of these. If you develop chest pain, fainting or a racing or irregular heartbeat once on treatment, contact your prescriber or GP promptly.

A few practical points on how the medicines behave. The usual stimulants are short-acting, so they mostly work on the day they are taken — a missed dose generally just means the difficulties return that day rather than causing withdrawal, and they can usually be stopped without trouble. A couple of the non-stimulant options work differently and should not be stopped suddenly, so always make any changes with your prescriber. Regular review is essential, and medication tends to work best supporting rather than replacing practical changes.

Medication is best thought of as a tool that helps some people function better. Choosing to try it, and choosing not to, are both reasonable decisions when made with clear information.

Practical adjustments at work

Many helpful adjustments are simple and low-cost, and a lot of them help a wide range of people, not only those with or waiting for a diagnosis. It often helps to ask for them directly and concretely rather than in general terms. Some that tend to help:

1. **Ask for things in writing.** Written instructions, and a short email of actions after a meeting, are far easier to retain than the spoken word alone.
2. **Get priorities and deadlines made explicit.** Clear priorities, concrete deadlines, and work broken into smaller steps reduce the overwhelm of a vague, open-ended task.
3. **Protect a focus block.** Where scheduling is flexible, keep your best hours for focused work and arrange meetings elsewhere.
4. **Alter the environment.** A quieter space, fewer interruptions, and permission to use headphones or noise-reducing tools can all help concentration.
5. **Have check-ins.** Short, regular check-ins keep things on track better than being left alone and assumed to be progressing.

When you ask, being specific and matter-of-fact tends to help. For example:

- “I take things in far better written down — could you put the actions in an email after we speak?”
- “I focus best in the mornings; could we keep that block for focused work and put meetings in the afternoon?”
- “I lose the thread in long meetings. A short agenda beforehand makes a real difference.”
- “To get this right, I need the priority order — which of these is most important to deal with first?”

You do not need a diagnosis to make reasonable requests like these, though a formal diagnosis can help where adjustments need to be put on a firmer footing.

Managing daily life and energy

A few suggestions here, with the full understanding that you are the expert in what works for you. The aim of these is to rely less on memory and willpower, and more on structures, and they are the type of thing that tends to help:

1. **Get it out of your head.** Use one capture place for everything — one list, one app, one notebook — rather than scattered notes you have to remember to check.
2. **Reduce the decisions.** Every small choice spends attention. Laying clothes out the night before, a repeatable breakfast, or a set weekly shop can all free up capacity.
3. **Work in short blocks.** A stretch of focus followed by a short break is more sustainable than trying to push through, and lowers the cost of getting started.

4. **Plan the recovery, not just the task.** Put a gap after anything demanding, rather than stacking hard things back to back.
5. **Aim for "good enough."** Perfectionism and procrastination are often different aspects of the same problem. Done and imperfect usually beats perfect and unstarted.

Burnout tends to build when someone runs on effort and self-control alone, which are finite resources for everyone, so using some of this type of structure as you see fit can help self-control and discipline go further.

While waiting for assessment or medication

Waits for assessment and treatment are long and, in many places, getting longer — which is frustrating and demoralising, and can make it feel as though life is on hold. I have seen so many times people becoming more distressed because of relying entirely on a future prescription or assessment. This can sometimes be even more frustrating if a diagnosis is made and then due to system pressures there is a further wait of months of longer to start medication, which can increase this 'in limbo' feeling. Being realistic about the difference a diagnosis or medication will make, so that hopes are not pinned entirely on them, and remembering that adjustments can be made and that skills and strategies can be built, both before and alongside any other interventions, can help.

When to seek help sooner

- Persistent low mood, anxiety, panic or poor sleep can look like ADHD and can make it worse. Do not wait for an assessment to get help with them. Speak to your GP.
- If you are having thoughts of harming yourself or ending your life, get help the same day. Contact your GP, call NHS 111 and choose the mental health option, or ring Samaritans on 116 123 at any time. If you are in immediate danger, call 999.
- If you are on medication and have chest pain, fainting or a racing or irregular heartbeat, contact your prescriber or GP promptly.

There is a fully referenced version of this material, if you'd like to read further into any of it.