ADHD vs. Anxiety Disorders

24-7 Shalom Psychiatry PLLC | Comprehensive differential diagnosis, testing, medication and psychotherapy framework | Children, adolescents and adults

Purpose. A proposed evidence-based clinical program for differentiating ADHD from anxiety disorders, recognizing comorbidity, and selecting individualized treatment. This guide summarizes DSM-5-TR criteria in original wording; it is not a reproduction of the copyrighted manual. Services and tests require appropriate clinician qualifications and local availability.

1. Why ADHD and anxiety are confused

Shared feature	ADHD pattern	Anxiety pattern
Poor concentration	Persistent distractibility, forgetfulness and task switching, including during calm periods	Attention consumed by worry, perceived danger, panic or fear of evaluation
Restlessness	Long-standing motor activity, fidgeting or internal drive	Tension, hypervigilance, agitation associated with threat
Procrastination	Difficulty initiating, sequencing or sustaining work	Avoidance driven by fear of mistakes, uncertainty or feared consequences
Sleep problems	Delayed schedule, bedtime disorganization, variable sleep	Difficulty falling or staying asleep because of worry or arousal
Emotional reactivity	Impulsive frustration and difficulties regulating responses	Fear, apprehension and anticipatory distress

Key distinction: ADHD is a neurodevelopmental disorder with childhood onset and cross-setting persistence; anxiety disorders are characterized by disproportionate fear or anxiety, avoidance and disorder-specific symptom patterns. Both may be present simultaneously. Neither symptom relief with stimulants nor worsening with stimulants alone establishes a diagnosis.

2. DSM-5-TR ADHD criteria: complete clinical framework

Criterion A: At least six inattentive symptoms and/or six hyperactive-impulsive symptoms for individuals younger than 17; at least five in either domain at age 17 or older. Symptoms persist for at least six months, are developmentally inappropriate and adversely affect functioning.

Nine inattention manifestations: (1) careless errors/poor attention to detail; (2) difficulty sustaining attention; (3) seems not to listen; (4) fails to follow through; (5) disorganization; (6) avoids sustained mental effort; (7) loses needed items; (8) easily distracted; (9) forgetfulness.

Nine hyperactivity/impulsivity manifestations: (1) fidgeting; (2) leaving seat; (3) excessive running/climbing or adult restlessness; (4) difficulty engaging quietly; (5) acting as if driven by a motor; (6) excessive talking; (7) blurting answers; (8) difficulty waiting; (9) interrupting or intruding.

Additional criteria: Several symptoms before age 12; several symptoms in two or more settings; clear functional impairment; symptoms not occurring exclusively during psychosis and not better explained by another mental disorder. Document severity (mild/moderate/severe), partial remission if applicable, and presentation.

ADHD presentation	Description / ICD-10-CM
Predominantly inattentive	Inattention threshold met, hyperactive-impulsive threshold not met; F90.0

ADHD presentation	Description / ICD-10-CM
Predominantly hyperactive/impulsive	Hyperactive-impulsive threshold met, inattention threshold not met; F90.1
Combined	Both symptom thresholds met; F90.2
Other specified / unspecified ADHD	Clinically significant symptoms not meeting full criteria or insufficient specification; F90.8 / F90.9

3. DSM-5-TR anxiety disorders: diagnostic summaries

Each diagnosis additionally requires clinically significant distress or impairment, exclusion of substance/medical causes where applicable, and assessment of competing psychiatric explanations. The following are concise paraphrases, not full verbatim DSM text.

Generalized anxiety disorder (F41.1)

DSM-5-TR summary: Excessive anxiety and worry about multiple domains on more days than not for at least 6 months; difficult to control; at least 3 of restlessness, fatigue, concentration difficulty, irritability, muscle tension, sleep disturbance (only 1 required in children).

Treatment approach: CBT with worry exposure and cognitive restructuring; SSRIs/SNRIs commonly first-line; buspirone or other options selected individually.

Panic disorder (F41.0)

DSM-5-TR summary: Recurrent unexpected panic attacks; at least one followed by 1 month or more of persistent concern about further attacks/consequences or maladaptive behavior change; exclude physiological and other psychiatric causes.

Treatment approach: Panic-focused CBT with interoceptive exposure; SSRIs/SNRIs; avoid routine long-term benzodiazepines.

Agoraphobia (F40.00)

DSM-5-TR summary: Marked fear/anxiety in at least 2: public transportation, open spaces, enclosed spaces, lines/crowds, being outside home alone; fears escape/help difficulty; situations nearly always provoke fear, are avoided or endured with distress; typically 6+ months.

Treatment approach: Graduated in-vivo exposure-based CBT; SSRIs/SNRIs if indicated.

Social anxiety disorder (F40.10)

DSM-5-TR summary: Marked fear of scrutiny in social situations; fears negative evaluation; situations almost always provoke anxiety and are avoided/endured; disproportionate; typically 6+ months; specify performance-only when appropriate.

Treatment approach: Social-anxiety CBT with behavioral experiments and exposure; SSRIs/SNRIs; limited situational beta-blocker use for performance symptoms in selected adults.

Specific phobia (F40.298 or subtype-specific code)

DSM-5-TR summary: Marked fear of particular object/situation; almost always provokes immediate fear; avoidance/endurance; disproportionate; typically 6+ months. Specify animal, natural environment, blood-injection-injury, situational or other type.

Treatment approach: Exposure therapy is primary treatment; medication rarely primary.

Separation anxiety disorder (F93.0 in childhood; F93.0 often used across ages)

DSM-5-TR summary: Developmentally inappropriate, excessive separation fear; at least 3 symptoms (distress, worries about losing attachment figures, fear of separation events, refusal to go out, fear alone, refusal to sleep away, nightmares, physical complaints); at least 4 weeks in children/adolescents and typically 6+ months in adults.

Treatment approach: Family-inclusive CBT, graduated separation exposures; SSRIs for impairing cases when indicated.

Selective mutism (F94.0)

DSM-5-TR summary: Consistent failure to speak in certain social settings despite speaking elsewhere; interferes with functioning; at least 1 month (not just first school month); not due to unfamiliarity with language or communication disorder.

Treatment approach: Behavioral interventions, stimulus fading, shaping, school-family collaboration; SSRI sometimes adjunctive.

Substance/medication-induced anxiety disorder

DSM-5-TR summary: Prominent anxiety or panic temporally linked to intoxication, withdrawal or medication exposure; evidence of causation; not better explained by independent anxiety disorder.

Treatment approach: Identify and address substance/medication cause, withdrawal safety, and residual anxiety.

Anxiety disorder due to another medical condition

DSM-5-TR summary: Prominent anxiety/panic with evidence of direct physiological cause (e.g., endocrine or cardiopulmonary condition); not better explained by another mental disorder.

Treatment approach: Treat underlying medical condition; provide symptom-focused psychiatric care as needed.

Other specified anxiety disorder (F41.8)

DSM-5-TR summary: Clinically significant anxiety with stated reason full criteria are not met, e.g., limited-symptom attacks or short-duration syndrome.

Treatment approach: Treat predominant syndrome and impairment with targeted psychotherapy; medication case by case.

Unspecified anxiety disorder (F41.9)

DSM-5-TR summary: Clinically significant anxiety where reason for subthreshold classification is not specified or information is insufficient.

Treatment approach: Continue diagnostic clarification and symptom-focused care.

4. Conditions with anxiety symptoms but outside DSM-5-TR anxiety chapter

PTSD and acute stress disorder are trauma- and stressor-related disorders; **OCD** is obsessive-compulsive and related; **illness anxiety disorder** is somatic symptom and related; **adjustment disorder with anxiety** is trauma- and stressor-related. Assess each when the clinical pattern warrants it; they should not be mislabeled as anxiety-disorder subtypes.

5. Diagnostic workflow: distinguishing ADHD, anxiety and both

1. Timeline and onset: Ask what began first, whether attention problems preceded anxiety, whether symptoms occurred before age 12, and whether anxiety is episodic, situation-specific or pervasive.

2. Context and functional impairment: Obtain home, school, work and social examples; compare concentration when relaxed versus worried; examine avoidance versus executive dysfunction.

3. Collateral history: Request caregiver/teacher reports and school records for youth; consider adult school records and informants with consent.

4. Structured symptom assessment: Use ADHD and anxiety scales as adjuncts, not diagnostic substitutes; conduct full DSM-5-TR interview.

5. Psychiatric and medical differential: Assess depression, bipolar disorder, trauma, OCD, autism, learning disorders, sleep deprivation, substances, medication effects, thyroid and other relevant medical conditions.

6. Integrated formulation: Document separate evidence for each diagnosis, impairment, safety findings, severity, functional goals and rationale for treatment sequencing.

6. Screening instruments and specialty tests

ADHD-focused	Anxiety-focused / other
ASRS-5, DIVA-5, CAARS 2, BAARS-IV, Vanderbilt, Conners 4, ADHD-RS-5, BRIEF-2	GAD-7, SCARED, RCADS, PARS, HAM-A, SPIN/LSAS, PDSS, Panic Disorder Severity Scale, Mobility Inventory for agoraphobia
Optional QbTest, TOVA, Conners CPT, psychoeducational/neuropsychological assessment for selected indications	PHQ-9, MDQ, PCL-5, Y-BOCS, AUDIT-C/CRAFFT, sleep questionnaires when indicated

Required? Clinical interview, DSM-based history, functional assessment, differential diagnosis, risk assessment and appropriate collateral are central. No single rating scale, computerized test, EEG, MRI, genetic panel or neuropsychological battery is universally required or diagnostic for ADHD or anxiety.

7. Physical assessment, labs and medical investigations

Test / assessment	When to use; what it clarifies
Blood pressure, pulse, weight; height/growth for youth	Baseline before ADHD medication and follow-up; cardiovascular and growth monitoring
CBC, ferritin/iron studies	When anemia, fatigue, restless legs, poor nutrition or blood loss is suspected
TSH/free T4	When thyroid dysfunction may explain anxiety, palpitations, restlessness or cognitive complaints
CMP, B12, folate, glucose/A1c	Only when history, diet, medications or examination suggest metabolic/nutritional disease
Pregnancy testing	When pregnancy status affects medication selection and testing is appropriate with consent
Urine toxicology	When clinically indicated for substance-related differential or risk monitoring, consistent with policy and consent
ECG/cardiology assessment	Cardiac symptoms, concerning history, examination or interacting drugs; not universally required before ADHD medication
Sleep study, hearing/vision testing	When sleep apnea, other sleep disorders or sensory deficits are suspected
Neuropsychological/academic testing	When learning disorder, cognitive impairment, diagnostic complexity or accommodation needs warrant referral

Do not order broad laboratory panels routinely to diagnose ADHD or anxiety. Investigations are chosen from symptoms, medical history, examination and medication-specific safety needs.

8. ADHD medication management: selection, process, goals and risks

Class / examples	How managed; therapeutic goal	Common / important adverse effects
Methylphenidate / dexmethylphenidate (Concerta, Ritalin, Focalin)	Start age-appropriate formulation at labeled dose; titrate by response and duration; target sustained attention, task completion and impulsivity.	Appetite loss, insomnia, headache, abdominal pain, BP/HR rise; misuse/diversion, rare serious cardiac or psychiatric events.
Amphetamine / lisdexamfetamine (Adderall, Vyvanse)	Select based on daily coverage, history and tolerability; titrate and monitor.	Appetite loss, insomnia, anxiety/jitteriness, BP/HR rise; misuse/diversion, rare mania/psychosis.
Atomoxetine	Daily nonstimulant; titrate; assess response over several weeks; useful when stimulants are unsuitable.	Nausea, reduced appetite, fatigue, sexual effects; boxed warning for suicidal ideation in children/adolescents, rare liver injury.
Viloxazine ER	Daily nonstimulant; monitor symptom trajectory and interactions.	Somnolence, decreased appetite, insomnia, nausea; boxed suicidality warning, possible mania, BP/HR changes.
Guanfacine ER / clonidine ER	Often pediatric options; gradual titration; monitor BP, pulse and sedation; taper rather than stop abruptly.	Sleepiness, dizziness, hypotension, bradycardia; rebound hypertension if abruptly stopped.

Medication process: Confirm diagnostic criteria and impairment; review cardiac and psychiatric history, current medicines, substance use and diversion risk; agree on measurable goals; discuss options, consent, risks and monitoring; initiate and titrate according to FDA labeling and individual response. Review symptoms, appetite, sleep, mood, blood pressure/pulse and growth in youth. Do not assume anxiety is a contraindication to stimulants; monitor for worsening arousal and reassess treatment if needed.

9. Anxiety medication management: selection, process, goals and risks

Medication group	Indications and clinical approach	Common / serious risks
SSRIs: sertraline, escitalopram, fluoxetine, paroxetine	Often first-line for GAD, panic, social anxiety and selected pediatric anxiety; start low, titrate gradually; assess over weeks. FDA indications vary by drug and age.	GI upset, headache, sleep changes, sexual dysfunction, activation; suicidality warning in younger people, serotonin syndrome, discontinuation symptoms.
SNRIs: venlafaxine XR, duloxetine	Options for GAD and selected anxiety conditions; monitor BP, response and withdrawal risk.	Nausea, sweating, insomnia, sexual dysfunction; BP elevation (especially venlafaxine), discontinuation symptoms.
Buspirone	Scheduled dosing for GAD; delayed onset; not a rapid rescue treatment.	Dizziness, nausea, headache; drug interaction considerations.
Hydroxyzine	Short-term or intermittent relief in selected cases; avoid assuming disease-modifying benefit.	Sedation, anticholinergic effects, impaired driving, QT concerns in susceptible patients.
Benzodiazepines: lorazepam, clonazepam, alprazolam	Limited short-term/select cases after careful risk-benefit review; generally not preferred long-term.	Sedation, cognitive impairment, falls, dependence, withdrawal, overdose especially with opioids/alcohol.
Propranolol	Selected performance-related autonomic symptoms; not broad first-line anxiety treatment.	Bradycardia, hypotension, fatigue; caution with asthma and certain cardiac conditions.

Medication group	Indications and clinical approach	Common / serious risks
Pregabalin / other off-label choices	Consider only when evidence, jurisdiction, comorbidities and prior response justify use.	Dizziness, sedation, edema, weight gain, misuse potential; interaction risks.

Medication process: Match treatment to the specific anxiety disorder and severity; explain delayed onset of antidepressants, gradual titration, activation and withdrawal risks; assess suicidality and bipolar history; review drug interactions, pregnancy considerations and patient preference. Track both symptom reduction and functional gains. For specific phobia, exposure therapy rather than medication is generally central.

10. Psychotherapy: how it is delivered and its goals

ADHD-focused CBT: Typically structured weekly sessions: identify problem situations; externalize planning with calendars/task lists; break tasks into steps; use implementation intentions, time blocking and homework review. Goal: reliable task initiation, completion, reduced impairment and improved self-efficacy.

Behavioral parent training: Teach caregivers positive reinforcement, clear instructions, predictable routines, immediate feedback and consistent consequences; practice between sessions. Goal: improve child functioning and reduce coercive family cycles.

Organizational skills training: Teach binder/digital systems, assignment tracking, reminders, workspace organization and daily planning with rehearsal and feedback. Goal: improve school/work performance.

CBT for generalized anxiety: Use psychoeducation, monitoring worry triggers, cognitive reappraisal, intolerance-of-uncertainty exercises, worry exposure and reduction of reassurance-seeking. Goal: less uncontrolled worry and better functioning.

Exposure therapy for phobias, social anxiety and agoraphobia: Build collaboratively ranked fear hierarchy; practice repeated gradual exposure without excessive safety behaviors; review learning and repeat between sessions. Goal: reduce avoidance and improve independent functioning.

Panic-focused CBT: Explain panic physiology, identify catastrophic misinterpretations, use interoceptive exposure and real-world exposure where indicated. Goal: reduce fear of bodily sensations and avoidance.

CBT for selective mutism / separation anxiety: Use developmentally appropriate gradual exposure, shaping, reinforcement, parent/school coordination and separation practice. Goal: increase speaking or separation tolerance across settings.

ACT, mindfulness and DBT-informed skills: Optional adjuncts for values-based action, distress tolerance and emotional regulation; do not substitute for disorder-specific first-line treatments when those are indicated.

11. Treatment sequencing when both diagnoses are present

ADHD predominant: Treat ADHD with medication and executive-function supports while monitoring anxiety. **Anxiety predominant:** Begin disorder-specific CBT/exposure and consider SSRI/SNRI where indicated; reassess attention after anxiety improves. **Both impairing:** A coordinated plan may treat both, staged or concurrent according to severity, patient preference and safety. Avoid reflexively attributing all inattention to anxiety or all worry to ADHD. Assess suicidality, mania, psychosis, substance use and medication interactions throughout.

12. Follow-up and measurement-based care

Record baseline ADHD and anxiety scales, individualized goals, sleep, work/school function, medication adherence and adverse effects. During titration, review frequently enough to make safe adjustments; once stable, monitor periodically and conduct at least annual comprehensive medication review. Use GAD-7/SCARED/PDSS and ASRS/ADHD-RS or equivalent measures consistently, alongside actual functional outcomes. Reassess diagnosis when treatment response is atypical.

13. Selected references and clinical guidance

1. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). https://doi.org/10.1176/appi.books.9780890425787

2. Centers for Disease Control and Prevention. (2026). Clinical care of ADHD in children. https://www.cdc.gov/adhd/hcp/treatment-recommendations/

3. Centers for Disease Control and Prevention. Diagnosing ADHD. https://www.cdc.gov/adhd/diagnosis/index.html

4. National Institute for Health and Care Excellence. (2018, updated). Attention deficit hyperactivity disorder: diagnosis and management (NG87). https://www.nice.org.uk/guidance/ng87/chapter/recommendations

5. Merck Manual Professional Edition. Overview of anxiety disorders. https://www.merckmanuals.com/professional/psychiatric-disorders/anxiety-and-trauma-and-stressor-related-disorders/overview-of-anxiety-disorders

6. American Academy of Pediatrics. (2019). Clinical practice guideline for the diagnosis, evaluation, and treatment of ADHD in children and adolescents. Pediatrics, 144(4), e20192528. https://doi.org/10.1542/peds.2019-2528

7. National Institute for Health and Care Excellence. (2011, updated). Generalised anxiety disorder and panic disorder in adults: management (CG113). https://www.nice.org.uk/guidance/cg113

8. National Institute for Health and Care Excellence. (2013). Social anxiety disorder: recognition, assessment and treatment (CG159). https://www.nice.org.uk/guidance/cg159

9. U.S. Food and Drug Administration. Drugs@FDA: FDA-approved drug labeling and safety information. https://www.accessdata.fda.gov/scripts/cder/daf/

Practice note: This is a proposed clinical framework for 24-7 Shalom Psychiatry PLLC, not a claim that every test or intervention is offered on-site. Verify current FDA labeling, licensing, payer policies and state-specific requirements before implementation.