GERIATRIC PSYCHIATRY · CLINICAL DIDACTIC

Optimal Management of ADHD in Older Adults

A synthesis of current evidence on recognition, differential diagnosis, and multimodal treatment of ADHD across the aging brain.

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Learning Objectives

By the end of this session, participants will be able to:

1. **Recognize ADHD presentations in late life**
   Identify how inattentive and hyperactive-impulsive symptoms present differently once patients reach older adulthood.

2. **Review epidemiology and neurobiology**
   Summarize prevalence estimates and the frontostriatal/catecholamine mechanisms thought to underlie the disorder.

3. **Understand the diagnostic approach in older adults**
   Apply a structured history, collateral-information, and screening strategy tailored to geriatric patients.

4. **Differentiate ADHD from cognitive disorders**
   Distinguish lifelong attentional traits from the progressive decline seen in MCI, dementia, and mood disorders.

5. **Review pharmacologic and psychotherapy treatments**
   Compare stimulant, non-stimulant, and behavioral options and how the evidence applies to older patients.

6. **Apply geriatric-specific safety principles**
   Incorporate cardiovascular monitoring, polypharmacy review, and 'start low, go slow' dosing into care.

Why This Topic Matters

- ADHD is increasingly recognized as a disorder that persists across the entire lifespan, not just a childhood condition.
- Many older adults remain undiagnosed for decades and only come to clinical attention later in life.
- Unaddressed symptoms continue to affect occupational function, quality of life, and family relationships well into older age.
- Geriatric psychiatrists are encountering a growing number of diagnostic dilemmas as awareness of adult ADHD increases.

CLINICAL SIGNAL

Rising recognition of adult ADHD, combined with an aging population, means more clinicians will be asked to evaluate long-standing attentional complaints in patients over 65 — often for the first time.

SECTION 01

Foundations of ADHD in Late Life

Definitions, diagnostic criteria, and the core symptom domains that anchor every later comparison.

Definition of ADHD

- A neurodevelopmental disorder characterized by persistent inattention and/or hyperactivity-impulsivity.
- By definition, symptoms begin in childhood — this developmental origin is central to diagnosis at any age.
- Symptoms must be persistent and impair functioning across two or more settings (e.g., home, work, social life).
- The outward presentation evolves substantially across the lifespan, even though the underlying trait persists.

LIFESPAN VIEW

Think of ADHD as a continuous trait whose visible expression changes shape with age — overt hyperactivity in childhood gradually gives way to internal restlessness and executive dysfunction in later adulthood.

DSM-5 Diagnostic Criteria

Five core requirements must all be satisfied for a formal diagnosis.

1. **Inattention symptom cluster**
   A qualifying number of inattentive symptoms present, per DSM-5 thresholds.

2. **Hyperactivity/impulsivity symptom cluster**
   A qualifying number of hyperactive-impulsive symptoms present, or a combined presentation.

3. **Onset before age 12**
   Several symptoms must have been present before age 12, even if formally diagnosed later.

4. **Impairment in 2+ settings**
   Functional impairment must be evident across at least two settings, not confined to one context.

5. **Not better explained by another disorder**
   Symptoms are not solely attributable to another psychiatric or medical condition.

Core Inattention Symptoms

Six hallmark features clinicians should probe for during history-taking.

1

Forgetfulness

Missing appointments, bills, or routine obligations despite intending to complete them.

2

Poor organization

Difficulty sequencing tasks, managing paperwork, or maintaining systems over time.

3

Difficulty sustaining attention

Attention wanes during lectures, reading, or prolonged conversations.

4

Losing items

Frequently misplacing keys, glasses, medications, or important documents.

5

Distractibility

Easily pulled off-task by unrelated stimuli or intrusive thoughts.

6

Difficulty completing tasks

Starting projects enthusiastically but rarely finishing them.

Core Hyperactivity/Impulsivity Symptoms

In adults these often present internally rather than as overt motor activity.

1

Restlessness

A subjective sense of needing to move, even when outward fidgeting has faded.

2

Excessive talking

Difficulty pausing in conversation or over-explaining routine matters.

3

Interrupting others

Jumping into conversations before others have finished speaking.

4

Impatience

Low tolerance for waiting in lines, traffic, or slow-moving processes.

5

Difficulty waiting

Discomfort tolerating delay before acting on a thought or urge.

6

Feeling internally driven

A persistent inner sense of urgency, 'as if driven by a motor.'

How ADHD Changes with Aging

The visible symptom profile shifts substantially, even as core impairment persists.



1 — Overt hyperactivity decreases

Visible fidgeting and motor restlessness lessen with age.

2 — Internal restlessness persists

A subjective sense of unease or drive often remains.

3 — Executive dysfunction remains prominent

Planning, initiation, and organization deficits stay central.

4 — Coping strategies mask symptoms

Decades of adaptation can obscure the underlying disorder.

5 — Retirement uncovers impairment

Loss of external structure often reveals symptoms clearly.

SECTION 02

Epidemiology, Neurobiology & Presentation

How common ADHD is in later life, what drives it biologically, and how it shows up clinically.

Epidemiology

ADHD in older adults is uncommon to diagnose — but not uncommon to have.

1–4%

Estimated prevalence of ADHD in older adults

↓

Symptom severity may decline with age, yet remain impairing

↑

Underdiagnosis remains common across settings

- Older women may be especially underrecognized, often attributed to anxiety or personality traits instead.
- Because ADHD is still viewed as a childhood condition by many clinicians, late-life presentations are frequently missed on first contact.

Why ADHD Is Missed in Older Adults

Five overlapping barriers contribute to underdiagnosis.

1. **Symptom overlap with depression and anxiety**
   Concentration and motivation complaints are shared across these diagnoses, muddying the picture.

2. **Resemblance to mild cognitive impairment**
   Executive dysfunction can look identical to early neurocognitive decline on a brief exam.

3. **Generational stigma about psychiatric illness**
   Older cohorts may be reluctant to disclose or pursue a psychiatric label.

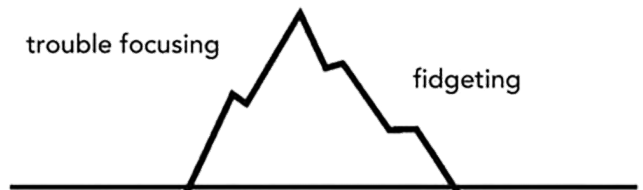
4. **Lack of clinician awareness**
   Many providers were trained to view ADHD strictly as a childhood disorder.

5. **Compensatory strategies mask symptoms**
   Decades of self-developed routines can conceal significant underlying impairment.

THE ADHD ICEBERG

@FINUCCINIALFREDO

WHAT PEOPLE THINK ADHD IS:



WHAT ADHD ACTUALLY IS:

sensory processing disorder

poor sense of time

financial problems

'all or nothing'

difficulty maintaining relationships

anxiety

trouble recalling commonly used words

uncontrollable fidgeting

depression

sleeping problems

auditory processing disorder

difficulty following and maintaining conversations

hyperfixations

mood swings

rejective sensitive dysphoria

trouble regulating emotions

executive dysfunction

inability to focus even if there are no distractions

losing items relentlessly

chronic unemployment

poor impulse control

forgetting to eat, sleep, go to the bathroom

difficulty switching tasks or inability to stick to one

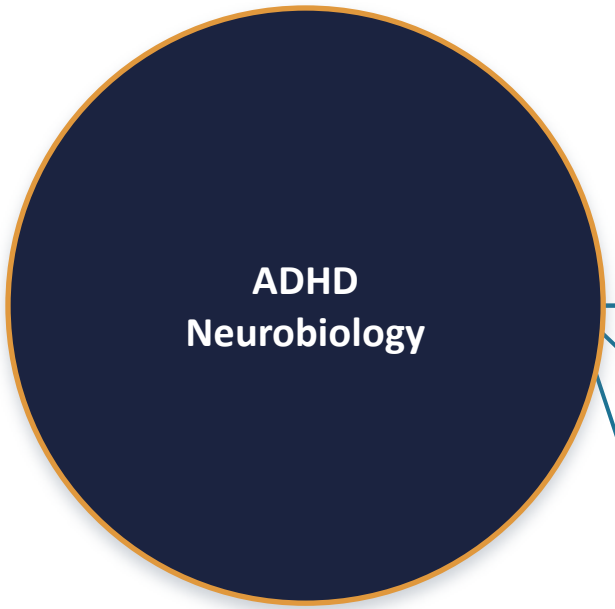
forgetting thoughts 0.2 seconds after having them

problems focusing on things even if they are of interest

choice paralysis

Neurobiology of ADHD

Executive dysfunction sits at the center of a shared neural circuit disruption.



Frontostriatal dysfunction
Disrupted circuitry linking prefrontal cortex and striatum underlies core deficits.

Catecholamine dysregulation
Imbalanced neurotransmitter signaling affects attention and self-regulation.

Dopamine & norepinephrine pathways
Both systems are directly implicated and are the target of pharmacotherapy.

Executive dysfunction, centrally
Nearly all clinical features trace back to impaired executive control.

Executive Dysfunction in ADHD

One unifying deficit explains a wide range of everyday difficulties.



Planning difficulties
Trouble breaking goals into sequential, actionable steps.

Working memory impairment
Trouble holding and manipulating information moment-to-moment.

Task initiation problems
Difficulty starting activities even when motivated to do them.

Disorganization
Struggles maintaining consistent systems for tasks and belongings.

Poor time management
Chronic underestimation of how long tasks will take.

Clinical Presentation in Older Adults

Executive dysfunction surfaces in very concrete, everyday ways.

1

Missed appointments

Recurrent no-shows despite reminders and stated intentions.

2

Chronic lateness

A lifelong pattern of running behind schedule, not situational.

3

Difficulty managing finances

Late bills, disorganized records, impulsive purchases.

4

Clutter and disorganization

Persistent, visible disarray at home or in the workspace.

5

Relationship strain

Forgetfulness and interrupting behaviors erode trust over time.

6

Emotional dysregulation

Disproportionate frustration or reactivity to minor stressors.

Functional Impairment

ADHD's impact extends well beyond attention itself.

1. **Reduced occupational performance**
   Missed deadlines and inconsistent output, even in experienced workers.

2. **Relationship instability**
   Recurrent conflict tied to forgetfulness, distractibility, or impulsivity.

3. **Driving problems**
   Elevated risk of distraction-related incidents and near-misses.

4. **Financial difficulties**
   Impulsive spending and disorganized bill payment.

5. **Poor medication adherence**
   Forgotten doses complicate management of comorbid medical conditions.

Psychiatric Comorbidity

ADHD rarely presents in isolation — comorbidity is the rule, not the exception.

1

Major depressive disorder

Frequently co-occurs and can obscure the underlying attentional disorder.

2

Anxiety disorders

Chronic worry may develop secondary to years of functional struggle.

3

Bipolar disorder

Overlapping impulsivity and distractibility complicate differentiation.

4

Substance use disorders

Self-medication of attentional or mood symptoms is common.

5

Sleep disorders

Disrupted sleep both results from and worsens ADHD symptoms.

Medical Comorbidity

Medical burden is highly relevant to both diagnosis and treatment safety.

1

Hypertension

Common in this population and directly relevant to stimulant safety.

2

Obesity

May relate to impulsive eating patterns and reduced activity.

3

Chronic pain

Can worsen concentration and be mistaken for primary inattention.

4

Sleep apnea

Produces attentional symptoms that closely mimic ADHD.

5

Cardiovascular disease

A key safety consideration before initiating stimulant therapy.

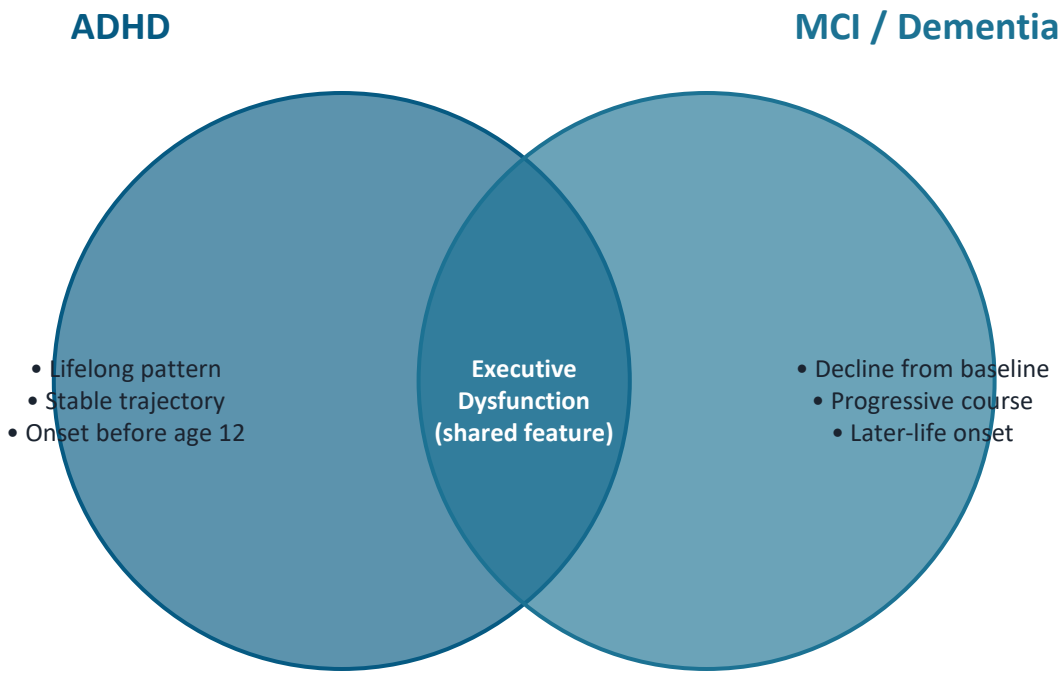
SECTION 03

Differential Diagnosis

Separating lifelong ADHD from the progressive and mood-related conditions it is most often confused with.

ADHD and Cognitive Disorders

Both conditions involve executive dysfunction, which is precisely why they are so often confused.



KEY DISTINCTION

ADHD is a lifelong, stable trait. MCI and dementia represent decline from a prior baseline. When both involve executive dysfunction, ask: has this always been true, or is it new and worsening?

Differentiating ADHD from MCI

Course over time is the single most useful discriminator.

ADHD	Mild Cognitive Impairment
✦ Lifelong symptoms, present since childhood	✦ Progressive decline from a prior baseline
✦ Chronic disorganization described since youth	✦ New onset in later life, not lifelong
✦ Symptom pattern is stable over decades	✦ Collateral history is extremely helpful in distinguishing the two

Differentiating ADHD from Dementia

Independence and trajectory separate these conditions.

ADHD	Dementia
✦ Symptoms are usually stable over time	✦ Progressive loss of independent function
✦ Memory complaints often reflect attention deficits, not true amnesia	✦ Neuropsychological testing may help clarify the pattern
✦ Independent function is generally preserved	✦ Decline is the defining feature, not stability

ADHD vs Depression

Motivation deficits overlap heavily, making history essential.

ADHD	Depression
✦ Symptoms typically predate any mood episode	✦ Reduced concentration is secondary to mood symptoms
✦ Inattention is trait-like and chronic	✦ Onset is episodic, not lifelong
✦ Motivation deficits are tied to executive dysfunction	✦ Treating depression alone may not resolve executive dysfunction

Diagnostic Decision Pathway

A simplified way to organize the differential before committing to a diagnosis.



1 — Symptoms since childhood?

Yes points toward ADHD; no points elsewhere.

2 — Progressive decline noted?

Yes raises concern for MCI or dementia.

3 — Mood episode came first?

Yes suggests depression-driven inattention.

4 — Collateral history obtained

Confirms trajectory and childhood onset.

5 — Working diagnosis formed

Integrate all findings before treatment planning.

SECTION 04

Diagnostic Assessment

A structured, multi-source evaluation is what makes an accurate diagnosis possible.

Initial Assessment

Six components form the backbone of a thorough evaluation.

1. **Detailed psychiatric history**
   Explore symptom onset, course, and prior treatment attempts.

2. **Developmental history**
   Establish evidence of symptoms before age 12.

3. **Family history**
   ADHD has a strong heritable component worth documenting.

4. **Functional impairment assessment**
   Quantify impact across occupational, social, and domestic domains.

5. **Medical review**
   Screen for conditions that mimic or worsen attentional symptoms.

6. **Medication review**
   Identify agents that could contribute to inattention or restlessness.

Importance of Childhood History

- DSM-5 requires that several symptoms have been present before age 12, making childhood history essential.
- School performance records can offer objective clues, even decades later.
- Behavioral reports from teachers or parents, when available, are highly informative.
- Family interviews are often essential when the patient's own recollection is incomplete.

PRACTICAL TIP

Old report cards, standardized test score patterns, and recollections from siblings or classmates can substitute for records that no longer exist.

Collateral Information

Multiple independent sources strengthen diagnostic confidence.

1

Spouse/family reports

Provide an outside perspective on long-standing patterns.

2

Old report cards

Offer objective, contemporaneous evidence of childhood struggles.

3

Occupational history

Reveals a pattern of underperformance relative to ability.

4

Prior psychiatric evaluations

May contain overlooked clues pointing toward ADHD.

5

Functional observations

Direct observation can reveal disorganization not self-reported.

Screening Tools

No single tool is diagnostic — each contributes a piece of the picture.

ASRS

- ✦ Adult ADHD Self-Report Scale
- ✦ Widely used, brief screening measure
- ✦ Good for initial triage in clinic

Wender Utah

- ✦ Retrospective childhood symptom scale
- ✦ Helps establish developmental onset
- ✦ Useful when records are unavailable

Brown ADD Scale

- ✦ Emphasizes executive function domains
- ✦ Captures organization and self-regulation
- ✦ Complements symptom-count measures

Role of Neuropsychological Testing

A useful adjunct — not a stand-alone diagnostic tool.

1. **Can help characterize cognitive profile**
   Clarifies patterns of strength and weakness across domains.

2. **Useful when dementia/MCI is suspected**
   Helps distinguish progressive decline from lifelong traits.

3. **Not diagnostic by itself**
   Results must always be interpreted alongside clinical history.

4. **Interpretation complicated by comorbidities**
   Depression, anxiety, and medical illness can all skew results.

Medical Evaluation

Ruling out mimics and contributors is a required step before diagnosis.

1

Rule out thyroid disease

Thyroid dysfunction can produce prominent attentional symptoms.

2

Assess sleep disorders

Untreated apnea or insomnia frequently masquerades as ADHD.

3

Review medications

Identify agents that impair attention or increase restlessness.

4

Consider hearing/vision impairment

Sensory loss can be misread as inattention or disengagement.

5

Assess substance use

Alcohol or sedative use can significantly cloud the clinical picture.

Assessment Pathway, Start to Finish

The full workup, arranged in the order it typically unfolds.



1 — Psychiatric & developmental history

Establish onset, course, and functional impact.

2 — Collateral information

Corroborate the history with outside sources.

3 — Validated screening tools

Apply ASRS, Wender Utah, or Brown ADD Scale.

4 — Medical workup

Exclude thyroid, sleep, sensory, and medication causes.

5 — Neuropsychological testing (if indicated)

Reserved for diagnostic ambiguity or suspected decline.

SECTION 05

Treatment: Pharmacotherapy

A multimodal approach anchored by cautious, evidence-guided medication management.

Treatment Overview

Effective care combines several complementary strategies.



Pharmacotherapy
Stimulant and non-stimulant medications, carefully titrated.

Psychotherapy
CBT and skills-based coaching to build durable strategies.

Behavioral/environmental modifications
Structural changes that reduce day-to-day demands on attention.

Caregiver and family involvement
Support systems that reinforce treatment and monitor safety.

Treatment Goals

Success is measured in function, not just symptom counts.

1. **Improve attention and executive functioning**
   Target the core cognitive deficits directly.

2. **Reduce functional impairment**
   Translate symptom improvement into real-world gains.

3. **Enhance quality of life**
   Address the downstream emotional and relational toll.

4. **Improve occupational/social functioning**
   Support continued engagement in meaningful roles.

5. **Minimize adverse effects**
   Balance benefit against the unique risks of an older population.

Stimulants Overview

- Stimulants carry the most robust evidence base for ADHD treatment across age groups.
- Methylphenidate and amphetamine formulations are the most commonly used agents.
- Response rates may remain favorable even in older adults who have not previously been treated.
- Evidence specific to geriatric populations remains limited compared to younger cohorts.

EVIDENCE NOTE

Most stimulant trials were conducted in younger adults, so dosing and safety data in older patients are extrapolated rather than directly studied — reinforcing the need for cautious titration.

Methylphenidate

A frequently first-line stimulant option in older adults.

1. **Improves attention and concentration**
   Core benefit reflecting its catecholaminergic mechanism.

2. **Can help motivation and initiation**
   Reduces the 'stuck' feeling common in executive dysfunction.

3. **Start at low doses**
   Geriatric dosing should begin well below typical adult starting doses.

4. **Monitor appetite, blood pressure, and sleep**
   These are the most common early tolerability concerns.

Amphetamine Preparations

- ✦ Long-acting formulations are often preferred for smoother symptom coverage across the day.
- ✦ May produce meaningful improvement in executive functioning alongside attention.
- ✦ Potential risks include insomnia, hypertension, and anxiety, all of which warrant monitoring.

CAUTION

Cardiovascular and psychiatric side effects deserve particularly close attention in older patients with pre-existing hypertension or anxiety disorders.

Atomoxetine

A non-stimulant alternative with a distinct risk-benefit profile.

1. **Nonstimulant norepinephrine reuptake inhibitor**
   Mechanistically distinct from traditional stimulant medications.

2. **Useful when stimulants are contraindicated**
   A reasonable option in patients with significant cardiac risk.

3. **May benefit anxiety comorbidity**
   Can be advantageous in patients with coexisting anxiety.

4. **Monitor blood pressure and liver effects**
   Regular monitoring is warranted given its side-effect profile.

Alpha-2 Agonists

A more cautious option reserved for select clinical situations.

1. **Limited evidence in older adults**
   Data specific to geriatric patients remain sparse.

2. **Potential sedation and hypotension**
   These effects are particularly relevant in frail patients.

3. **May help emotional dysregulation**
   Can be useful when irritability or reactivity is prominent.

4. **Use cautiously in geriatrics**
   Reserve for cases where other options are unsuitable.

Medication Comparison at a Glance

A side-by-side summary of the four major pharmacologic classes.

Class	Mechanism	Key Consideration	Monitoring Priority
Methylphenidate	Dopamine/NE reuptake inhibition	Start low, favorable response rates	Appetite, BP, sleep
Amphetamine preps	Dopamine/NE release & reuptake block	Long-acting formulations preferred	BP, insomnia, anxiety
Atomoxetine	Selective NE reuptake inhibition	Option when stimulants contraindicated	BP, hepatic effects
Alpha-2 agonists	Central alpha-2 adrenergic agonism	Reserve for select cases	Sedation, hypotension

Dosing Guidelines for Stimulants				
Brand Name(s)	**Generic Name**	**Starting Daily Dose (adults)**	**Increase Dose Adjustment per Week**	**Max Daily Dose (adults)**
Adderall	Mixed amphetamine salts IR	5–10 mg QAM or BID	5–10 mg	40–60 mg
Adderall XR	Mixed amphetamine salts ER	10–20 mg	5–10 mg	40–60 mg
Adhansia XR	Methylphenidate ER	25 mg	10–15 mg	100 mg
Evekeo	Amphetamine IR	5–10 mg	5–10 mg	60 mg
Adzenys XR	Amphetamine ER	12.5 mg if not taking Adderall XR	3.1–6.3 mg	18.8 mg
Dyanavel XR	Amphetamine ER	5–10 mg	5–10 mg	20 mg
Azstarys	Serdexmethylphenidate/ dexmethylphenidate ER	39.2 mg/7.8 mg		52.3 mg/10.4 mg
Concerta, Relexxii	Methylphenidate ER	18–36 mg	18 mg	72 mg
Jornay PM	Methylphenidate ER	20 mg	20 mg	100 mg
Mydayis	Mixed amphetamine salts ER (triple bead formulation)	12.5 mg	12.5 mg	50 mg
Ritalin, Methylin	Methylphenidate IR	10–20 mg	10–20 mg	60 mg
Ritalin LA, Metadate CD	Methylphenidate ER	10–20 mg	10–20 mg	60 mg
Ritalin SR, Metadate ER, Methylin ER	Methylphenidate ER	10–20 mg	10–20 mg	60 mg
Vyvanse	Lisdexamfetamine	30 mg	10–20 mg	70 mg

Source: Physician's Desk Reference

Cardiovascular Risk Assessment

A required safety step before initiating any stimulant.

1. **Review cardiac history**
   Document any prior cardiac events, arrhythmias, or structural disease.

2. **Measure BP and pulse before treatment**
   Establish a clear baseline before any dose is given.

3. **Consider ECG in high-risk patients**
   Especially relevant with pre-existing cardiac conditions.

4. **Assess for arrhythmias or structural heart disease**
   These findings may significantly change the treatment plan.

Common Side Effects

Expected effects to discuss proactively with patients and families.

1

Insomnia

Often dose- and timing-related; address with scheduling adjustments.

2

Reduced appetite

Monitor weight, especially in frail or underweight patients.

3

Weight loss

Track over time; more consequential in older, lower-weight adults.

4

Anxiety

May emerge or worsen with stimulant initiation.

5

Tachycardia

Warrants prompt evaluation if new or persistent.

6

Hypertension

Requires regular blood pressure monitoring throughout treatment.

Geriatric Prescribing Principles

Five habits that anchor safe pharmacologic care in older adults.



1 — Start low and go slow

Begin below typical adult doses and titrate gradually.

2 — Monitor closely

Track response and tolerability at frequent intervals.

3 — Avoid polypharmacy

Minimize unnecessary concurrent medications where possible.

4 — Review drug interactions

Reassess the full regimen with each new prescription.

5 — Reassess risks and benefits regularly

Revisit the treatment plan as health status evolves.

SECTION 06

Psychotherapy & Non-Pharmacologic Care

Behavioral, cognitive, and environmental strategies that complement medication.

Psychotherapy Approaches

Non-pharmacologic strategies form an essential part of comprehensive care.

1

Cognitive behavioral therapy

Targets organizational skills and unhelpful thought patterns.

2

Skills-based coaching

Builds practical strategies for daily task management.

3

Organizational strategies

Concrete systems for managing time, tasks, and belongings.

4

Mindfulness approaches

Supports attentional regulation and emotional awareness.

5

Supportive psychotherapy

Addresses the emotional toll of a lifetime of undiagnosed symptoms.

CBT for ADHD

- ✦ Improves organization and planning through structured, skills-based techniques.
- ✦ Addresses the negative self-perception that often accumulates after decades of undiagnosed struggle.
- ✦ Can improve coping strategies for everyday executive-function demands.
- ✦ Serves as a useful adjunct to medication rather than a replacement for it.

WHY IT WORKS

CBT gives patients concrete tools for the gap medication doesn't close — turning improved attention into consistent follow-through on daily tasks.

Environmental Interventions

Structural changes that reduce the burden on working memory and attention.

1

Structured routines

Predictable daily patterns reduce reliance on moment-to-moment recall.

2

Calendars and reminders

External scaffolding compensates for working-memory limitations.

3

Medication organizers

Simple tools that meaningfully improve adherence.

4

Reducing clutter

A simplified physical environment supports sustained attention.

5

Simplifying tasks

Breaking large tasks into smaller, more manageable steps.

Family and Caregiver Education

Involving the support system meaningfully improves outcomes.

1. **Improve understanding of symptoms**
   Reframes behaviors as symptoms rather than character flaws.

2. **Reduce interpersonal conflict**
   Shared understanding lowers frustration on both sides.

3. **Support treatment adherence**
   Families can help reinforce routines and medication schedules.

4. **Encourage behavioral strategies**
   Caregivers can help implement organizational systems at home.

SECTION 07

Special Populations & Safety

Additional considerations that shape safe, individualized care in older adults.

Special Considerations in Older Adults

Five factors that should shape every treatment decision.

1

Polypharmacy

Multiple concurrent medications raise interaction risk substantially.

2

Falls risk

Sedation or dizziness from any agent can compound existing risk.

3

Sleep disorders

Both cause and consequence of ADHD symptoms in this population.

4

Medical comorbidity

Chronic conditions shape medication choice and monitoring intensity.

5

Sensory impairment

Hearing or vision loss can complicate both diagnosis and treatment.

ADHD and Sleep

- Insomnia is common among older adults with ADHD, whether from the disorder itself or its treatment.
- Sleep apnea can independently worsen attention, further complicating the clinical picture.
- Treating underlying sleep disorders may meaningfully improve cognitive symptoms.
- Medication timing is an important, often overlooked lever for improving sleep quality.

PRACTICAL TIP

Screen for sleep apnea before attributing daytime inattention entirely to ADHD — treating it can be the single highest-yield intervention.

ADHD and Substance Use

- Higher rates of nicotine and alcohol use are observed among adults with ADHD.
- Careful monitoring for substance use is warranted throughout treatment.
- Extended-release stimulant formulations may reduce the risk of misuse compared to immediate-release agents.

SAFETY NOTE

A history of substance use does not preclude stimulant treatment, but it should inform formulation choice and monitoring frequency.

SECTION 08

Evidence, Cases & Conclusions

Where the literature stands today, a clinical case, and the key messages to carry forward.

Strengths of the Reviewed Literature

What the current evidence base gets right.

1. **Addresses an understudied population**
   Fills a real gap in the ADHD literature focused on older adults.

2. **Integrates diagnosis and treatment**
   Offers a practical, end-to-end clinical framework.

3. **Clinically practical recommendations**
   Guidance is directly applicable at the bedside.

4. **Highlights gaps in evidence**
   Transparently identifies where more research is needed.

Limitations of Current Evidence

Important caveats to keep in mind when applying these findings.

1. **Few randomized controlled trials**
   Much of the evidence base remains observational rather than experimental.

2. **Small sample sizes**
   Limits the precision and generalizability of existing findings.

3. **Limited geriatric-specific studies**
   Most ADHD research still centers on children and younger adults.

4. **Reliance on observational data**
   Increases the risk of confounding in treatment-outcome conclusions.

Future Research Directions

Priority areas that would meaningfully strengthen the evidence base.

1

Long-term stimulant safety

Data on extended use in older adults remain limited.

2

Neuroimaging studies

Could clarify how ADHD neurobiology evolves with age.

3

Psychotherapy outcomes in older adults

Dedicated trials of CBT and coaching in this population are needed.

4

ADHD and dementia overlap research

Understanding shared mechanisms could improve differential diagnosis.

Case Example

A representative presentation that ties the framework together.

“72-year-old retired engineer with lifelong disorganization, referred for possible mild cognitive impairment.”

- ✦ History revealed childhood inattention and long-standing occupational struggles predating any cognitive decline.
- ✦ Collateral history from family confirmed a stable, lifelong pattern rather than a progressive one.
- ✦ Symptoms improved with structured CBT combined with a low-dose stimulant, supporting an ADHD diagnosis over MCI.

Clinical Pearls

Five habits to carry into everyday practice.

1. **Always assess lifelong symptom pattern**
   Chronicity since childhood is the most powerful diagnostic clue.

2. **Do not assume all cognitive complaints represent dementia**
   ADHD remains a plausible, treatable alternative explanation.

3. **Cardiovascular assessment is essential**
   A non-negotiable step before any stimulant trial.

4. **Psychotherapy can be highly beneficial**
   Often underutilized relative to its demonstrated value.

5. **Functional impairment matters as much as symptom count**
   Real-world impact should guide the urgency of treatment.

Discussion Questions

Prompts to guide group conversation.

1. **How do you differentiate ADHD from MCI in practice?**

2. **When should stimulants be avoided altogether?**

3. **What role should neuropsychological testing play?**

4. **How should clinicians monitor stimulant safety over time?**

KEY TAKEAWAYS

What to Carry Forward

1. ADHD persists into older adulthood, even when its outward presentation changes.
2. Diagnosis requires a careful developmental history, not just a current symptom checklist.
3. Treatment can meaningfully improve function and quality of life at any age.
4. The evidence base remains limited but is growing steadily.
5. Geriatric psychiatrists should maintain a high index of diagnostic awareness.

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- Optimal management of ADHD in older adults.
- Neuropsychiatric Disease and Treatment. 2016;12:79–87.
- PMCID: PMC4712975

SOURCE ARTICLE

This didactic synthesizes and expands upon the findings of the above peer-reviewed review article on ADHD management in older adults.

THANK YOU

Questions & Discussion

Open floor — happy to discuss cases, evidence, or practice implications.