

AUDHD

When Autism and ADHD Occur Together

Statistics, presentation, co-occurring conditions, and evidence-based support

WHAT IS AUDHD?

AuDHD is the informal but widely used term for the co-occurrence of Autism Spectrum Disorder (ASD) and Attention-Deficit/Hyperactivity Disorder (ADHD) in the same individual. It is not a separate clinical diagnosis, rather, it describes a dual neurotype in which two distinct neurodevelopmental profiles overlap, interact, and create an experience that is meaningfully different from either condition alone.

Until 2013, clinicians were explicitly prohibited from diagnosing both conditions simultaneously, the DSM-IV listed autism as an exclusionary criterion for ADHD. The DSM-5 removed this restriction, formally recognizing that both conditions can and frequently do coexist. As a result, many adults who were previously diagnosed with only one condition are now being re-evaluated and recognized as AuDHD.

One way researchers have described the AuDHD experience: autism might be thought of as the color red, ADHD as the color blue, and AuDHD as purple, more than a sum of its parts; something new in itself (Researchers, Disability & Society, 2024). The internal experience of AuDHD is shaped by the interaction between two neurotypes, producing a profile that requires its own lens.

A note on language: AuDHD is a community-generated term increasingly used in clinical and research literature. Some individuals prefer the term "autistic with ADHD" or "co-occurring ASD and ADHD." We use AuDHD throughout this fact sheet as a clear, inclusive shorthand. The most important thing is accurate recognition, not the label.

STATISTICS: HOW COMMON IS AUDHD?

50–70% of individuals with autism also meet criteria for ADHD, according to a meta-analysis of 63 studies (Rong et al., 2021; YOU Psychiatry Clinic, 2025).

~40% pooled current prevalence of ADHD among people with autism spectrum disorder, based on a meta-analysis of 56 studies (Rong et al., 2021, ScienceDirect).

~13% of children diagnosed with ADHD are also diagnosed with ASD, with higher rates in younger children (Attention-Deficit/Hyperactivity Disorder and Autism Spectrum Disorder, PMC, 2024).

10x higher rate of ADHD among adults with autism without intellectual disability compared to the general population, in a study of 3.5 million Medicaid-enrolled adults (Yerys et al., JAMA Network Open, February 2025).

1 in 36 children in the U.S. is identified with autism (CDC, 2023 ADDM Network data). Given the high co-occurrence rates above, AuDHD is far more common than most people realize.

These numbers reflect diagnosed rates, which almost certainly undercount the true prevalence. Because AuDHD presentations can mask each other and because diagnostic tools were designed for each condition separately, many individuals remain unrecognized for years, particularly women, girls, and people from BIPOC communities.

WHY AUTISM AND ADHD SO FREQUENTLY CO-OCCUR

The high co-occurrence of autism and ADHD is not coincidental. Research has identified overlapping neurobiological mechanisms underlying both conditions.

- **Shared genetics:** There is substantial genetic overlap between ASD and ADHD. Twin studies show that autistic individuals are more susceptible to also having ADHD than the general population, suggesting shared heritable vulnerabilities in brain development.
 - **Shared brain structures:** Neuroimaging studies have found comparable volume decreases in basal ganglia structures (putamen, amygdala, nucleus accumbens) in both ASD and ADHD compared to controls, alongside differences in prefrontal-subcortical connectivity. Both conditions involve differences in dopamine signaling and reward processing (PMC, 2024).
 - **Shared cognitive domains:** Executive function, attention regulation, emotional processing, and social cognition are affected in both conditions, though through partially different mechanisms. The overlap means that individuals with both conditions face compounded challenges in these areas.
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PRESENTATION: HOW AUDHD LOOKS AND FEELS

AuDHD does not look like ADHD plus autism added together. It looks like a unique neurotype with its own patterns, contradictions, and internal experiences. One of its most distinctive features is the internal conflict generated by the opposing pulls of its two neurotypes.

The Core Tension: Novelty vs. Routine

ADHD drives the brain toward novelty, stimulation, impulsivity, and a craving for what is new and interesting. Autism often drives the brain toward predictability, routine, deep familiarity, and aversion to unexpected change. Living with both means navigating a near-constant internal negotiation: "I need structure, but I'm bored by it. I want to try something new, but change distresses me. I want connection, but social situations exhaust me."

As many AuDHD individuals describe it: "I want order but cannot maintain it. I crave routine but become bored by it. I want to be systematic and precise but struggle with it." This inner contradiction is not a personality inconsistency, it is a neurological one.

Common AuDHD Experiences

- **Hyperfocus and deep special interests:** The ADHD capacity for intense absorption combined with the autistic drive toward deep mastery of specific interests can produce extraordinary expertise and passion. The same combination can also produce difficulty shifting away from those interests when other responsibilities demand attention.
- **Sensory processing differences:** Both ADHD and autism involve sensory sensitivity, and in AuDHD the sensory profile is often more pronounced. Individuals may experience hypersensitivity to noise, light, textures, and crowds alongside occasional hyposensitivity (seeking intense sensory input for regulation). Environments that are tolerable for neurotypical people may be genuinely overwhelming for someone with AuDHD.
- **Executive dysfunction, compounded:** Both conditions impair executive function. In AuDHD, the effects compound: ADHD makes it hard to start tasks and manage time; autism may make transitions and task-switching additionally difficult, particularly when routines are interrupted.
- **Emotional dysregulation:** Emotional dysregulation is more severe in individuals with co-occurring ASD and ADHD than in either condition alone (Reimherr et al., 2018; YOU Psychiatry Clinic, 2025). Emotions are felt intensely, regulation is harder, and recovery takes longer. Rejection Sensitive Dysphoria (RSD), already common in ADHD, may be heightened further by the social communication differences of autism.
- **Social complexity:** ADHD may create impulsive social enthusiasm, interrupting, or oversharing. Autism may create difficulty reading social cues, social exhaustion, or a need for explicit communication. Together, an AuDHD individual may deeply want connection while finding social interaction both genuinely confusing and genuinely exhausting. Being socially interested and socially drained at the same time is common.
- **Cyclical energy and burnout:** Many AuDHD individuals experience intense bursts of energy, productivity, and engagement followed by significant crashes. The ADHD drive to pursue stimulation can deplete the nervous system reserves that autism requires for stability, creating cycles of high output and collapse that are difficult to predict or prevent.

- **Masking at double intensity:** Both autistic masking (suppressing sensory and behavioral autistic traits to appear neurotypical) and ADHD masking (compensating for executive dysfunction through elaborate systems and effort) may operate simultaneously. Double-masking is extraordinarily cognitively and emotionally expensive, and is one of the primary drivers of AuDHD burnout.

How AuDHD Hides Itself

One of the most clinically significant features of AuDHD is that each condition can obscure the other, making both harder to identify.

- **ADHD masking autism:** ADHD characteristics, impulsivity, verbal expressiveness, social enthusiasm, chatty sociability, can directly contradict stereotypical presentations of autism. A child or adult who is talkative and energetic may not "look autistic" to clinicians trained on male-dominant, hyperactive presentations, causing the autism component to be missed entirely.
- **Autism masking ADHD:** An autistic person's strong drive for routine and structure may create the appearance of organization and planning, masking the ADHD-driven executive dysfunction that is operating underneath. They may appear "functional" at the cost of enormous compensatory effort.
- **Both masking each other in women:** The combination of female socialization (toward compliance, people-pleasing, and emotional suppression) with AuDHD neurology produces some of the most dramatically under-diagnosed presentations. Women with AuDHD receive multiple incorrect diagnoses, most commonly anxiety, depression, and personality disorders, before an accurate picture is reached (Russell et al., 2022; YOU Psychiatry Clinic, 2025).

What the experience of diagnosis often feels like: For many individuals who receive an AuDHD diagnosis, especially as adults, the evaluation process itself can feel profoundly validating. "Someone is finally connecting the dots." Long-standing patterns of struggle, contradiction, and self-doubt suddenly have a framework. Grief for the years unrecognized and relief at finally being seen often arrive together.

FREQUENT CO-OCCURRING CONDITIONS

Individuals with AuDHD have consistently higher rates of co-occurring conditions than those with either autism or ADHD alone. A 2022 real-world study found that AuDHD adults had the highest healthcare utilization of all neurodevelopmental cohorts, driven primarily by behavioral health needs (PMC, 2025). Understanding these co-occurring conditions is essential for whole-person care.

- **Anxiety disorders:** Among the most prevalent co-occurring conditions in AuDHD. The combination of sensory overload, social difficulty, executive dysfunction, masking demands, and difficulty predicting social situations creates near-constant conditions for anxiety to develop. Up to 40% of autistic children and adolescents experience anxiety disorders, and AuDHD elevates this further.
- **Depression:** Chronic masking, social isolation, repeated experiences of failing to meet neurotypical expectations, and the cumulative exhaustion of AuDHD burnout are all pathways to depression. Depression in AuDHD is often misidentified as the primary condition, with the underlying neurotype unrecognized.
- **AuDHD burnout:** A distinct and serious condition in its own right: a deep physical, cognitive, and emotional crash following sustained periods of masking, sensory overload, executive demand, or social effort. AuDHD burnout is more severe and longer-lasting than typical fatigue. Recovery requires genuine reduction of demand, not simply "rest" in the conventional sense.
- **Sleep disorders:** Both autism and ADHD independently carry elevated rates of sleep disorders, including delayed sleep phase, insomnia, and sensory-driven sleep disruption. In AuDHD, these risks compound. Many individuals with AuDHD report that disrupted sleep is one of their most impairing daily challenges.
- **Sensory Processing Disorder:** While sensory sensitivity is a diagnostic feature of autism, it is also common in ADHD. In AuDHD, sensory difficulties are typically more pronounced and more pervasive, affecting diet (food textures), clothing (tags, seams), sound tolerance, and the ability to function in standard educational and workplace environments.
- **Eating challenges / ARFID:** Avoidant/Restrictive Food Intake Disorder (ARFID) and other eating difficulties are significantly more common in the AuDHD population, driven by sensory sensitivity to textures, flavors, and temperatures, combined with the anxiety and rigidity that can accompany both conditions.

- **OCD and repetitive behaviors:** The repetitive behaviors and need for sameness in autism can overlap clinically with OCD, though they are distinct. In AuDHD, the combination of autistic rigidity and ADHD impulsivity can create complex patterns that require careful differential assessment.
 - **Substance use disorders:** A 2025 CHOP/JAMA Network Open study flagged substance use disorders as more prevalent among AuDHD adults, a finding consistent with the broader ADHD literature on impulsivity and the use of substances for self-regulation, stimulation, or as unrecognized self-medication.
 - **Learning disabilities:** Dyslexia, dyscalculia, and dyspraxia (developmental coordination disorder) co-occur with both ADHD and autism at elevated rates. In AuDHD, unidentified learning disabilities further compound academic and occupational difficulties.
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GETTING THE RIGHT DIAGNOSIS

Because AuDHD presentations are complex, contradictory, and often masked, accurate diagnosis requires a comprehensive, developmentally-informed evaluation that explicitly holds both possibilities in mind. Assessment tools designed for each condition separately may not capture the combined presentation, and brief screening measures are insufficient.

- **What comprehensive evaluation includes:** Clinical interview covering developmental history from birth; behavioral rating scales for both ADHD and autism; direct behavioral observation; input from family members or others who know the individual well; and cognitive and neuropsychological testing when indicated.
 - **Who should conduct it:** A clinician with specific training in both autism and ADHD, and ideally with experience in gender-informed and culturally responsive assessment. Many adults with AuDHD were evaluated by clinicians trained in one condition but not both.
 - **The masking problem in assessment:** Individuals who mask effectively may not show their difficulties during a clinical appointment. History, self-report of internal experience, and input from people who know the person across different settings are essential. A person who "presents well" in a brief appointment may be exhausted for three days afterward from the masking effort required.
 - **Late diagnosis in adults:** Many AuDHD adults are not identified until their 30s, 40s, or beyond, often triggered by burnout, by a child's diagnosis, or by growing community awareness. Late diagnosis, while emotionally complex, can be transformative: it reframes a lifetime of struggle, opens access to appropriate support, and gives individuals language for experiences they could not previously name.
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MANAGEMENT, TREATMENT & SUPPORT

AuDHD treatment is not simply the sum of autism treatment plus ADHD treatment. The interaction between the two conditions means that interventions must be calibrated for both simultaneously, and that what helps one neurotype may complicate the other. A person-centered, flexible, neurodiversity-affirming approach is essential.

1. Medication

Medication decisions in AuDHD require particular care and individualized monitoring. There is no medication approved specifically for autism, but ADHD medications can address attention, impulsivity, and executive dysfunction in AuDHD. Their effects, however, are more variable and sometimes more complicated than in ADHD alone.

- **Stimulants:** Stimulant medications (methylphenidate and amphetamine-based) remain first-line for ADHD symptoms in AuDHD and can be effective, but require careful monitoring for worsening sensory sensitivity, anxiety, rigidity, and sleep (clinical review, Orchestrate Health, 2025). For some individuals, stimulants may heighten already-elevated sensory sensitivity or reduce cognitive flexibility, making autistic traits more intense even as ADHD symptoms improve.
- **Non-stimulants:** Atomoxetine (Strattera), guanfacine ER (Intuniv), and viloxazine may be preferable for individuals with significant anxiety, sensory sensitivity to stimulants, or sleep disruption. Guanfacine has additional benefits for emotional regulation and sleep that may be particularly relevant in AuDHD.

- **"Start low, go slow":** Clinical consensus in AuDHD is to introduce medication at low doses, increase gradually, and review frequently against sleep, anxiety, and sensory load rather than symptom checklists alone (Orchestrated Health, 2025).
- **Co-occurring mental health conditions:** When anxiety or depression co-occur, SSRIs or SNRIs may be considered, but must be introduced cautiously in autistic individuals as these can cause activation or increased agitation. All medication decisions should involve a clinician with AuDHD-informed experience.

2. Neurodiversity-Affirming Therapy

Therapy for AuDHD works best when it is adapted for both neurotypes, affirms the person's neurodivergent identity rather than framing their traits as deficits, and addresses the significant emotional burden of masking and late diagnosis.

- **Autism-adapted CBT:** CBT modified for autistic cognition, more concrete, structured, visual, and explicit, has shown effectiveness for anxiety and emotional regulation in AuDHD. Standard CBT without adaptation may be inaccessible or less effective.
- **DBT (Dialectical Behavior Therapy):** DBT skills for emotional regulation, distress tolerance, and interpersonal effectiveness are well-suited to AuDHD, particularly for individuals with significant emotional dysregulation, RSD, or burnout patterns.
- **ACT (Acceptance and Commitment Therapy):** ACT's values-based approach and emphasis on psychological flexibility can be particularly powerful for AuDHD individuals navigating identity, self-acceptance, and the tension between their neurotype and neurotypical expectations.
- **Trauma-informed approaches:** A significant proportion of AuDHD adults carry trauma from years of misunderstanding, misdiagnosis, educational difficulties, social rejection, and the lived experience of trying to be something their neurology cannot sustain. Therapy that does not account for this dimension misses a critical piece of the picture.

3. Executive Function Coaching & Practical Support

- ADHD coaching adapted for AuDHD focuses on task initiation, planning, time management, and organization, while accounting for autistic preferences for explicit instruction, predictable structure, and low ambiguity.
- Visual supports (visual schedules, written checklists, explicit step-by-step plans) help both the ADHD brain (which needs external scaffolding) and the autistic brain (which benefits from predictability and reduced cognitive load).
- Transition support is particularly important: both ADHD and autism affect task-switching, and unplanned transitions can be disproportionately disruptive. Transition warnings, structured wind-down time, and clear signaling of what comes next reduce the dysregulation that transitions provoke.

4. Occupational Therapy (OT) & Sensory Support

- Occupational therapy addresses sensory processing, motor coordination, daily living skills, and adaptive functioning, all of which may be significantly impacted in AuDHD. OT is one of the most practically impactful interventions for everyday quality of life.
- Sensory accommodations, noise-canceling headphones, weighted blankets, adjusted lighting, sensory-friendly clothing, quiet spaces, are not indulgences. They are evidence-based environmental modifications that reduce the neurological load that would otherwise consume the regulatory capacity needed for everything else.
- Identifying individual sensory profiles (what is dysregulating vs. regulating for this specific person) is more useful than applying general sensory recommendations.

5. Burnout Prevention & Recovery

AuDHD burnout is one of the most serious and most frequently underrecognized consequences of living with unrecognized or under-supported AuDHD. Prevention is better than recovery, and recovery requires genuine, sustained demand reduction.

- **Prevention:** Reducing masking demands; building authentic environments (home, work, school) that do not require constant suppression of neurotype; maintaining sensory and regulatory routines; identifying and respecting energy limits before they are exceeded.
- **Recovery:** Rest that is sensory and neurologically restorative rather than merely passive. Engagement with special interests. Time in environments where masking is not required. Reduction of social and executive obligations to the minimum sustainable level. Recovery from severe burnout may take months.
- **Special interests as medicine:** Engagement with deep special interests is not merely enjoyable for AuDHD individuals, it is neurologically regulating. Dismissing or restricting special interest time is counterproductive. Supporting access to special interests is a meaningful clinical and caregiving intervention.

6. Educational & Workplace Accommodations

- AuDHD students and employees are entitled to accommodations under IDEA (K-12) and the ADA (higher education and employment). The combination of autism and ADHD typically warrants more extensive accommodation than either condition alone.
- Effective accommodations for AuDHD typically include: extended time; quiet testing environments; sensory modifications; written rather than verbal-only instructions; flexible scheduling; advance notice of transitions and changes; and reduced sensory stimulation in learning and work environments.
- School and workplace assessors benefit from understanding the AuDHD profile specifically: a student who appears to be performing adequately may be doing so at enormous neurological and emotional cost that is invisible in the grades and output.

7. Community & Peer Connection

- Connection with other AuDHD individuals, through support groups, online communities, or peer-led spaces, provides a uniquely validating experience: the recognition that one's internal contradictions are shared by others with the same neurotype, not signs of personal failure.
- The lived-experience AuDHD community is one of the most vibrant and well-informed sources of practical knowledge about what actually helps. Professional supports are more effective when they are complemented by peer community.
- Faith communities are uniquely positioned to offer genuine belonging, spaces where a person does not need to perform neurotypicality in order to be received with dignity. This is not a small thing for individuals who have spent their lives masking in order to be accepted.

A word to families and caregivers: If someone you love has received an AuDHD diagnosis, as a child or as an adult, the most important thing you can offer is an environment where they do not need to mask to be loved. That safety is not merely comfort. It is the neurological foundation from which genuine growth, learning, and flourishing become possible.

The Society for ADHD and Co-Occurring Conditions serves as a bridge between faith communities, and the evidence-based resources families need. We are here to equip you.

For resources, training, or speaking inquiries: info@societyforadhd.org | www.societyforadhd.org

References available upon request. All content is science-backed and evidence-based.