

UNDERSTANDING AuDHD



A new framework for
a misunderstood mind

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4th Edition

AuDHD is not a comorbidity

The friend who changed my life did it over coffee, which is appropriate because most of the important things in my life have happened within arm's reach of caffeine.

Gaye is a psychologist who has worked with veterans for years, helping us navigate the distance between service life and the civilian world, which can be a chasm dressed up as a career transition.

She is also one of the people who has seen me at my absolute worst and my bouncy best, which is a wider range than most friendships are asked to accommodate and which she has accommodated with the particular grace of someone who understands that both versions are the same person operating under different loads.

She asked me, with the studied innocence of someone who already knew the answer, whether I'd ever considered that I might be neurodivergent. She let me discover it for myself, which is what the best friends do. It is also what the best clinicians do, though the overlap between those two categories is rarer than the profession would like to admit.

What followed was an informal assessment. Not a formal one. My disability pension would not cover the considerable cost of a comprehensive diagnostic evaluation, which in Australia runs into the thousands and is means-tested by a system that apparently believes the people least able to afford assessment are the ones who need it least.

But there was a second reason the assessment remained informal, and it is the reason this chapter exists: a formal assessment would almost certainly have produced the wrong answer.

The diagnostic tools available to any clinician conducting a formal AuDHD evaluation are designed to identify two separate conditions. Autism assessment tools look for autistic traits. ADHD assessment tools look for ADHD traits. The training, the instruments, the scoring frameworks, the report templates, all of them are built on the assumption that you are measuring two things that happen to coexist in the same person.

It would be extremely unlikely that any diagnostician, however skilled, would be able to avoid separating the autism and ADHD sides of my brain, because the system they work within was designed to separate them.

The co-occurrence framing is not just a theoretical position. It is baked into the tools. And the tools, applied to me, would have produced a report describing two conditions sharing a nervous system, like flatmates who'd ended up in the same house by administrative accident and were now arguing about the thermostat, the grocery list, and whether silence constituted a valid form of communication.

Gaye, who knew me as a whole person rather than as a collection of symptoms to be sorted into diagnostic categories, could see something the formal tools would have missed: that my brain was doing something particular, coherent, and spectacularly poorly understood my entire life. Not two things. One thing, with a logic the diagnostic system had never been designed to recognise.

Something about that framing, the wholeness of it, bothered me for months afterward. Not because it was wrong. Because it was the first thing that had been right about my brain in four decades of psychiatric attention, a sentence that should probably concern someone at the Royal Australian and New Zealand College of Psychiatrists but almost certainly won't.

What kept nagging was the realisation that a formal assessment, the one I couldn't afford, might have been less accurate than the informal one I received from an educated friend who knew me, because the formal system would have produced exactly the two-conditions framing that my lived experience contradicted.

I wrote about the moment that recognition landed, what it felt like to discover at sixty-six that the question everyone had been asking about my brain for forty years was the wrong question, in the opening chapter of *Misdiagnosed*. I called it 'The question that changes everything,' because it does.

When you stop asking 'What's wrong with this person?' and start asking, 'What if the diagnostic framework is wrong about this person?' the entire landscape shifts. This chapter picks up where that one left off.

I've spent the fourteen months since that conversation with Gaye reading the research, talking to other AuDHD adults, working clinically with neurodivergent clients, and paying closer attention to my own brain than I have since my twenties, when I was mostly using it to make poor decisions about romantic partners and career choices, sometimes simultaneously.

What I've found is that the co-occurrence framing, whilst technically defensible, may be the wrong lens entirely. And that the wrong lens, applied for long enough, distorts everything downstream: the research, the clinical practice, the support structures, and most importantly, the way AuDHD people understand their own experience.

This chapter makes a different argument. AuDHD may not be autism plus ADHD. It may be its own thing.

HOW WE GOT THE QUESTION WRONG

To understand why the co-occurrence framing dominates, you need the history. And the history, like most histories of psychiatric classification, is a story about confident people being wrong in interesting ways for a surprisingly long time.

The Diagnostic and Statistical Manual of Mental Disorders—the DSM—is the reference book most clinicians in the English-speaking world use to classify mental health and neurodevelopmental conditions. It occupies a curious position in medicine: simultaneously

indispensable and routinely embarrassing, like a GPS that gets you to the right suburb but consistently parks you in the wrong driveway.

Until 2013, the DSM contained an explicit prohibition: you could not diagnose autism and ADHD in the same person. The DSM-IV stated that ADHD could not be diagnosed if the symptoms were better explained by an autism spectrum disorder. One or the other. Pick a lane.

This wasn't based on evidence that the conditions couldn't coexist. It was based on the diagnostic philosophy of the time, which preferred clean categories over messy reality. Autism went in one box. ADHD went in another. The boxes were assumed to be separate rooms in the same building, and nobody thought to check whether the wall between them was load-bearing or decorative.

Clinicians knew this was a problem. They'd been seeing children who clearly displayed features of both conditions for years.

A child whose social communication difficulties pointed toward autism but whose impulsivity and inattention screamed ADHD had to be filed under one label or the other—a process with all the diagnostic rigour of sorting laundry by guessing what colour it was before it faded.

The decision often came down to which symptoms were loudest in the assessment room on that particular day.

Autistic traits that manifested quietly—the sensory sensitivities, the internal rigidity, the grinding exhaustion of navigating unwritten social rules—could be overshadowed by the more visible ADHD presentation: the fidgeting, the interrupting, the spectacular inability to sit still during a forty-five-minute assessment designed by someone who apparently believed that sitting still for forty-five minutes was a reasonable thing to ask of any child, let alone a neurodivergent one.

The DSM-5, published in 2013, removed the exclusion criterion. For the first time, clinicians could officially diagnose both conditions in the same person. The American Psychiatric Association acknowledged, with the quiet understatement that characterises institutions admitting they've been wrong for decades, that the previous approach had been 'overly restrictive.'

Which is one way of putting it. Another way would be: we spent thirty years telling people their lived experience was diagnostically impossible, and we'd like to move on without discussing that too carefully.

The removal was genuine progress. But it came with a framing that embedded itself in everything that followed: two conditions, now permitted to coexist. Two diagnoses on the same report. Two sets of criteria, two bodies of research, two treatment literatures, applied to one person and stapled together.

I wonder whether that framing has been asking the wrong question ever since.

WHAT THE NUMBERS ACTUALLY TELL US

The co-occurrence statistics are striking enough to make you put your coffee down, which, given the attention span of the average AuDHD reader, is saying something. A meta-analysis of 63 studies by Rong and colleagues found that the pooled current prevalence of ADHD among autistic people was 38.5%, with a lifetime prevalence of 40.2% (Rong et al., 2021). Roughly four in ten autistic people also meet criteria for ADHD. That's not a statistical footnote. That's nearly half the population.

In Australia, autism affects approximately 1 in 40 people. ADHD affects around 6 to 10% of children and adolescents and 2 to 6% of adults. When you factor in the Rong co-occurrence rates, the population of people living with both conditions is far larger than the diagnostic infrastructure in most countries was built to identify or support. We're not talking about a rare overlap. We're talking about a substantial minority of all neurodivergent people, navigating a system designed on the assumption that they don't exist.

But here's where the statistics start telling a more interesting story than the co-occurrence framing allows.

A 2025 real-world study of 2.3 million insurance members found that people with both autism and ADHD had comorbidity patterns that were synergistically different from either condition alone (Thomas Craig et al., 2025). Not additive. Synergistic. The health profile of AuDHD was not 'autism health problems plus ADHD health problems.' It was something else—a distinct pattern that neither condition's literature predicted.

When two conditions produce outcomes that can't be explained by adding their individual effects together, the standard scientific response is to ask whether you're looking at a single phenomenon rather than two separate ones.

In chemistry, when two elements combine to produce something with entirely different properties, we call that a compound, not a mixture. Sodium is a metal that explodes in water. Chlorine is a gas that will kill you. Combine them and you get table salt, which does neither of those things and goes quite well on chips.

I wonder whether AuDHD might be a compound rather than a mixture. The research is beginning to suggest it might be.

WHEN TWO BECOMES SOMETHING ELSE

The lived experience of AuDHD, when you listen to the people inside it rather than reading about them in clinical abstracts, does not sound like two conditions taking turns. It sounds like a single system with its own particular, occasionally baffling, logic.

Consider the internal experience that most AuDHD adults describe: a simultaneous craving for routine and novelty. Not alternating. Simultaneous. The autistic architecture wants predictability, structure, sameness. The ADHD architecture wants stimulation, variety, the next interesting thing.

In the co-occurrence model, these are opposing forces pulling in different directions. In lived experience, they feel like a single river with crosscurrents—not two rivers flowing in opposite directions through the same landscape.

The Vanderbilt University Frist Center for Autism and Innovation has been exploring this complementary dynamic. Their work suggests that the autistic need for structure can actually help manage ADHD distractibility, providing scaffolding that pure ADHD brains lack. And ADHD's impulsivity can help autistic people break out of rigid routines that might otherwise calcify into paralysis.

The traits are not fighting each other. They're negotiating, constantly, in ways that produce something neither would produce alone.

I recognise this negotiation in my own experience with the weary familiarity of someone who has been living inside it for sixty-seven years without a manual.

My autistic capacity for deep, sustained focus on topics that engage me is extraordinary. I can disappear into research for days without sleep and surface knowing more about allostatic load than most people would consider reasonable or, frankly, attractive at dinner parties.

My ADHD makes that focus gloriously unreliable in any context that doesn't trigger my interest system—which includes most administrative tasks, most social obligations, and approximately 94% of what the neurotypical world considers 'normal adult responsibilities.'

But the two traits don't feel like separate forces. They feel like a single attention system operating by rules that nobody wrote a manual for, because nobody recognised it as a single system long enough to study it properly.

Late in 2025, a research team led by Priya Rajasethupathy at Rockefeller University published findings in *Nature Neuroscience* that may explain why (Rajasethupathy et al., 2025).

They identified a gene called *Homer1* that influences attention by shaping how quiet or noisy the brain is at rest. Mice with reduced levels of specific *Homer1* variants showed calmer baseline brain activity and performed better on tasks requiring focus.

Homer1 has been independently linked to both ADHD and autism—not as a gene for one condition that happens to affect the other, but as a gene involved in the neural processes both conditions share: sensory processing, attention regulation, and the filtering of relevant from irrelevant information.

If attention improves by reducing neural noise rather than increasing stimulation, then the traditional ADHD model—which frames the condition as a deficit requiring chemical amplification—may be addressing only half the mechanism.

And if the same genetic architecture influences both autistic sensory processing and ADHD attention regulation, the case for treating these as separate conditions sharing a body becomes

harder to sustain.

One gene study in mice does not overturn decades of clinical categorisation, and anyone who tells you otherwise is selling something. But the Homer1 findings join a growing body of evidence suggesting that the neural substrates of autism and ADHD overlap in ways that are structural, not incidental.

If that's true, then AuDHD isn't two conditions in one brain. It's one neurological profile that our diagnostic system, built on the assumption of separate categories, has been splitting in half.

WHAT THE PEOPLE INSIDE IT SAY

The most compelling evidence that AuDHD is its own thing comes not from genetics labs but from the people living it. And in 2026, the first formal phenomenological study of that lived experience was finally published—which tells you everything you need to know about the speed at which academia responds to questions communities have been answering for years.

Emma Craddock, writing in the journal *Health*, conducted interpretative phenomenological analysis of interviews with women diagnosed with both autism and ADHD in adulthood (Craddock, 2026). Her conceptualisation was striking: she framed AuDHD as a 'residual diagnostic category,' a condition not formally represented in diagnostic systems, existing in the space between two recognised diagnoses that don't quite capture what the person is experiencing.

Which is a polite academic way of saying: the filing system doesn't have a folder for you, so we've been jamming you into two folders at once and wondering why the edges don't line up.

What her participants described was not two conditions coexisting. They described a fluid, dynamic experience in which autistic and ADHD traits interacted to produce something that felt, from the inside, like a single way of being in the world.

The descriptions were revealing in their inconsistency: one participant called them 'two separate parts of my brain,' another described them as 'two sides of the same coin,' a third drew the distinction that 'autism is a part of me, ADHD is an add-on.'

These descriptions don't agree with each other. But they share something important: they're all improvisations. People trying to describe a unified experience using the only language the diagnostic system has given them, which is the language of two separate conditions.

When the available vocabulary doesn't match the lived reality, people improvise. And the improvisations, collected together, start to reveal the shape of what the vocabulary is missing.

Bridgette Hamstead, whose Substack has become one of the most important platforms for neurodiversity scholarship, argued in a March 2026 series that AuDHD research is undergoing a 'critical turn,' shifting from studying AuDHD as a subtype of one condition or the other toward recognising it as requiring its own phenomenology, its own research frameworks, and its own clinical approaches.

The field is beginning to treat AuDHD as a distinct entity. The diagnostic systems have not caught up. They rarely do. Diagnostic systems move at the speed of committees, and committees move at the speed of people who have never personally experienced the thing they're classifying.

WHAT CHANGES WHEN YOU CHANGE THE LENS

If AuDHD is an emergent profile rather than a co-occurrence, several things follow that matter practically, not just theoretically.

Assessment needs to change. Most existing diagnostic tools were developed for single conditions. Autism assessments look for autistic traits. ADHD assessments look for ADHD traits. Neither is designed to capture the interaction between them—the ways one set of traits modifies, masks, or amplifies the other.

An autistic person's rigid adherence to routine can suppress visible ADHD hyperactivity, making the ADHD invisible to an assessor looking for fidgeting. An ADHD person's social impulsivity can mask autistic social difficulties, making the autism invisible to an assessor looking for withdrawal. When the conditions interact, both can hide in plain sight—a neat trick if you're a magician and a catastrophe if you're a patient.

My AuDHD was identified informally at sixty-six, by a friend who knew me well enough to see the whole picture rather than the fragments a formal assessment would have produced. For the preceding forty years, the psychiatric system had been treating me for bipolar disorder, depression, and anxiety—a cascading sequence of misdiagnoses I documented in full in *Misdiagnosed*, for anyone who wants to understand what happens when the wrong question is applied to the right brain for four decades.

I responded poorly to every medication they tried, which they interpreted as treatment resistance rather than wrong diagnosis. Nobody asked whether the attention problems, the sensory sensitivities, the social exhaustion, and the relentless internal restlessness might be a single neurological profile rather than a collection of psychiatric symptoms. The question wasn't available, because the diagnostic framework didn't contain it.

I received treatment for conditions I didn't have, and no treatment for the condition I did, for longer than many of my readers have been alive.

Treatment approaches need rethinking. AuDHD medication management is notoriously complex because stimulant medications that help ADHD attention can increase autistic sensory sensitivity and anxiety, while strategies that help autistic overwhelm—reducing stimulation, increasing predictability—can worsen ADHD understimulation and boredom.

Treating the conditions as separate problems creates an impossible clinical game of whack-a-mole, where addressing one set of symptoms worsens the other. The mole, in this metaphor, is your entire nervous system, and the mallet is being wielded by someone who thinks there are two moles.

Treating AuDHD as a single profile with its own internal logic suggests a different approach: finding the interventions that work with the whole system rather than targeting half of it at a time.

And perhaps most importantly, self-understanding changes. The co-occurrence model tells AuDHD people they have two problems. The emergence model tells them they have one brain that works differently.

The emotional distance between those framings is enormous. I spent forty years believing I was broken in multiple ways simultaneously, which is exhausting in the way that only compound self-blame can be. Understanding that I have a single neurological architecture—coherent but different from the majority—didn’t eliminate the challenges. But it reframed them from evidence of compound failure to evidence of operating an unusual system without a manual.

That reframe shouldn’t matter as much as it does. But when you’ve spent decades believing you’re failing at being human in several different ways at once, discovering that you’re actually doing one unusual thing consistently is, in a way that’s genuinely difficult to convey to someone who hasn’t lived it, profoundly liberating.

THE MISCONCEPTIONS THAT PERSIST

Several misconceptions continue to complicate public understanding and clinical practice. They’re worth naming because you will encounter them, probably from well-meaning professionals who learned their neurodevelopmental psychiatry before the field caught up with the people it was studying.

The most persistent is the idea that autism and ADHD are incompatible because autism involves restricted interests and ADHD involves distractibility. This misunderstands both conditions with impressive efficiency.

Autistic restricted interests are not about inability to be distracted; they’re about the intensity and depth of focus when the interest system is engaged.

ADHD distractibility is not about inability to focus; it’s about unreliable deployment of focus across contexts. An AuDHD person can hyperfocus on their special interest for eight hours and be unable to sustain attention on a tax return for eight minutes, and this is not a contradiction. It’s the system working exactly as its architecture predicts. The architecture just wasn’t designed for tax returns, which may tell us more about tax returns than about the architecture.

The masking misconception is particularly damaging. If someone can appear neurotypical in social situations, the reasoning goes, they can’t have significant neurodevelopmental differences.

This is rather like arguing that because someone can run a marathon on a broken ankle, the ankle must be fine.

A woman who has learned to make appropriate eye contact, laugh at the right moments, and perform social ease while internally tracking seventeen unwritten rules and managing sensory

overload from the restaurant's lighting is not evidence that she's fine. She's evidence that masking is an extraordinary and unsustainable cognitive achievement that the diagnostic system routinely mistakes for health.

The timing misconception also causes real harm. Many people receive one diagnosis in childhood—usually ADHD if the hyperactivity is visible—and don't receive recognition of their autistic traits until adulthood, sometimes decades later. This creates the impression that the person 'developed' autism in midlife, which is neurologically nonsensical.

What happened is that the scaffolding—the routines, the relationships, the coping mechanisms keeping the autistic traits below clinical visibility—eventually collapsed under accumulated strain. The autism was always there. The diagnostic system couldn't see it until the supports gave way, at which point it was startled to discover something that had been present since birth. Diagnostic systems are frequently startled. It is one of their least endearing qualities.

A DIFFERENT STARTING POINT

The question is no longer whether autism and ADHD can co-occur. The DSM settled that in 2013, though it took the diagnostic establishment roughly three decades longer than it took the people living it. The question now is whether 'co-occurrence' is the right frame for what is actually happening when both conditions are present.

Whether the research that treats AuDHD as a subtype of autism, or a variant of ADHD, or a statistical overlap between two independent conditions, is missing something that the people living it have been trying to articulate for years.

The evidence is accumulating. The genetics suggest shared neural mechanisms. The epidemiology shows synergistic rather than additive health patterns. The phenomenology describes a unified experience that diagnostic language struggles to capture.

The community has been using the term AuDHD precisely because neither condition's label, applied alone or in combination, describes what it actually feels like from the inside.

This book takes that evidence seriously. Throughout the chapters that follow, AuDHD will be treated not as two conditions sharing a body but as a distinct neurological profile with its own internal logic, its own strengths, its own vulnerabilities, and its own requirements for understanding and support. The interaction is the thing itself, not a complication arising from two separate things.

The next chapter explores what that profile actually does in daily life—which is where the science meets the kitchen on a Tuesday morning when you've lost your keys for the third time whilst simultaneously remembering, in extraordinary detail, a conversation about quantum physics you had six years ago.

AuDHD is a particular kind of brain. Understanding it on its own terms is, I'd argue, the most interesting scientific and human question the neurodevelopmental field isn't quite asking yet.

Let's ask it.

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