

Diagnosis and Prescribing Patterns of Adult Attention-Deficit Hyperactivity Disorder in a Tertiary Care Hospital in the United Arab Emirates: A Retrospective Study

Mohammed Sallam ¹⁻³, Rula Albadri ^{2,4}, Nusrat N Khan ^{2,5}

¹Department of Pharmacy, Mediclinic Parkview Hospital, Mediclinic Middle East, Dubai, United Arab Emirates; ²College of Medicine, Mohammed Bin Rashid University of Medicine and Health Sciences (MBRU), Dubai Health, Dubai, United Arab Emirates; ³Department of Pharmacology and Therapeutics, College of Medicine and Health Sciences, United Arab Emirates University (UAEU), Al Ain, United Arab Emirates; ⁴Department of Family Medicine, Mediclinic Parkview Hospital, Mediclinic Middle East, Dubai, United Arab Emirates; ⁵Department of Psychiatry, Mediclinic Parkview Hospital, Mediclinic Middle East, Dubai, United Arab Emirates

Correspondence: Mohammed Sallam, Department of Pharmacy, Mediclinic Parkview Hospital, Mediclinic Middle East, Dubai, United Arab Emirates, Tel +97144168810, Email Mohammed.sallam@mediclinic.ae

Background: Adult attention-deficit hyperactivity disorder (ADHD) is increasingly recognized; however, evidence describing diagnostic pathways, comorbidity burden, and prescribing practices in adult care remains limited.

Purpose: To characterize diagnostic patterns, psychiatric comorbidities, and prescribing practices for adult ADHD across outpatient specialties in a tertiary care setting in the United Arab Emirates.

Methods: A retrospective chart review was conducted for adults aged ≥ 18 years diagnosed with attention-deficit hyperactivity disorder (ADHD) at a tertiary care hospital in Dubai, United Arab Emirates, between May 2023 and August 2024. Cases were identified using the ICD-10 code F90.x. Demographic characteristics, diagnosing specialty, ADHD diagnostic hierarchy and subtype, psychiatric comorbidities, and prescription data were extracted from electronic health records. Prescription data included ADHD-specific pharmacotherapy and medications for associated psychiatric or medical comorbidities. Descriptive statistics summarized diagnostic and prescribing patterns. One-way analysis of variance and chi-square tests examined differences in diagnostic yield across outpatient specialties and associations between diagnosis type, comorbidity presence, and prescribing patterns, with statistical significance set at $P < 0.05$.

Results: A total of 157 adult ADHD cases were identified. Psychiatry accounted for most diagnoses (60.5%), followed by family medicine (28.0%), neurology (10.2%), and internal medicine (1.3%). Diagnostic yield differed significantly across specialties ($F = 32.96$, $P < 0.001$). ADHD was documented as a secondary diagnosis in 60.5% of cases, most commonly with anxiety and depressive disorders, with comorbidity presence significantly associated with diagnosis type ($\chi^2 = 157.00$, $P < 0.001$). Inattentive and unspecified subtypes predominated ($\chi^2 = 85.82$, $P < 0.001$). Among 509 prescribed medications, methylphenidate accounted for 46% and was prescribed significantly more frequently than other agents ($\chi^2 = 314.21$, $P < 0.001$).

Conclusion: Adult ADHD was often diagnosed with psychiatric comorbidity, mainly in psychiatric services, with marked variation across specialties, highlighting the need for standardized diagnostic pathways and UAE-specific clinical guidance.

Keywords: neurodevelopmental disorder, psychiatry, adult ADHD, inattention, impulsivity, central nervous system stimulants

Introduction

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by persistent patterns of inattention, hyperactivity, and impulsivity across the lifespan.¹⁻⁷ Although ADHD is most commonly identified during childhood, symptoms frequently persist into adulthood, where they continue to exert clinically meaningful effects on functioning and quality of life.⁷⁻¹¹ Despite this persistence, adult ADHD remains substantially underrecognized, with delayed,

missed, or inaccurate diagnoses frequently reported in adult populations, particularly outside specialized psychiatric services.^{12–16} Estimates suggest that fewer than one in five adults with ADHD receive an accurate diagnosis and appropriate treatment, highlighting persistent gaps in recognition and management within routine healthcare systems.^{17–19}

The underdiagnosis of adult ADHD reflects a complex interplay of patient-level, provider-level, and system-level barriers. Stigma surrounding mental health conditions, cultural perceptions of neurodevelopmental disorders, and socio-economic disadvantage may hinder help-seeking and continuity of care, contributing to disparities in access and treatment adherence.^{1,20,21} Within healthcare systems, limited awareness of adult ADHD, diagnostic uncertainty, provider biases, financial constraints, including restricted insurance coverage, and insufficient access to specialized services further delay assessment and intervention, adversely affecting patient outcomes.^{17,22,23} These barriers are particularly relevant in general outpatient settings, where adult ADHD often presents alongside other psychiatric or medical conditions rather than as a primary diagnostic concern.

In adulthood, ADHD is associated with persistent functional impairments that extend beyond childhood academic difficulties to affect occupational performance, interpersonal relationships, and daily organization.^{1,24,25} Adults with ADHD commonly experience sustained difficulties with attention regulation, task initiation, and executive functioning throughout the day, resulting in cumulative functional burden.²⁶ These impairments are linked to reduced quality of life and significant health and economic consequences, including increased healthcare utilization, reduced productivity, and broader societal costs.^{6,27–31} Psychiatric comorbidities, particularly anxiety and depressive disorders, are highly prevalent among adults with ADHD and frequently complicate diagnostic assessment through symptom overlap and diagnostic overshadowing, contributing to diagnostic complexity and variability in clinical management.^{32–34} Improving recognition and management of adult ADHD has important clinical implications, including optimizing treatment outcomes, reducing functional impairment, and minimizing the burden of untreated comorbid conditions.

Globally, awareness of ADHD in adults has increased in recent years, supported by expanding research and evolving diagnostic frameworks.^{35,36} However, empirical evidence describing adult ADHD diagnosis, comorbidity patterns, and prescribing practices remains limited in the Middle East and Gulf region, including the United Arab Emirates (UAE), where available studies are few and heterogeneous.^{37–43} In particular, robust real-world clinical data are scarce on how adult ADHD is identified across outpatient specialties, the extent to which it is documented as a primary versus secondary diagnosis, and how pharmacological treatment is prescribed in the presence of psychiatric comorbidity.

To address these gaps, the present study conducts a retrospective analysis of adult ADHD cases managed within a tertiary care hospital in the UAE, aiming to characterize diagnostic patterns across outpatient specialties, the burden and distribution of psychiatric comorbidities, and pharmacological prescribing practices in routine adult ADHD care.

Materials and Methods

Study Design

This study was conducted and reported in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines for observational research.⁴⁴ A retrospective observational study design was employed, utilizing routinely collected clinical data extracted from the electronic health record (EHR) system.

Setting

The study was conducted at Mediclinic Parkview Hospital (MPAR), Dubai, United Arab Emirates. MPAR is a Joint Commission International (JCI)-accredited tertiary healthcare facility providing multidisciplinary outpatient and inpatient services across more than 46 medical specialties. Data extraction was performed using a structured abstraction framework to ensure consistency across records, enabling assessment of diagnostic practices across multiple outpatient specialties.⁴⁵

Study Population

The study population included all adult patients aged 18 years and above with a documented diagnosis of attention-deficit/hyperactivity disorder (ADHD), identified using clinician-documented ICD-10 (International Classification of Diseases,

Tenth Revision) diagnostic code F90.x, recorded in the electronic health record (EHR) between May 2023 and August 2024 (post-COVID-19 period). The date of diagnosis was defined as the first recorded diagnostic encounter at the study site. Prior ADHD diagnoses made outside the study institution (during childhood or in other healthcare settings) could not be systematically verified and were not distinguished from newly identified cases. All eligible cases meeting the diagnostic criterion during the study period were included, and no sampling was performed. The study size was therefore determined by the total number of eligible adult ADHD cases identified at the study site during the predefined study period.

Efforts to minimize selection and information bias included incorporating all eligible cases within the specified timeframe, using standardized ICD-10 diagnostic codes, and structured extraction of data from electronic health records.

Demographic and clinical variables extracted included age, gender, date of diagnosis (defined as the first recorded encounter with ICD-10 code F90.x at the study site), diagnosing outpatient specialty, ADHD diagnostic hierarchy (primary versus secondary diagnosis), ADHD subtype, psychiatric and neurological comorbidities, and prescription data. Prescription data captured both ADHD-specific pharmacotherapy and medications prescribed for associated psychiatric or medical comorbidities. Follow-up visits were recorded descriptively, and patient-level data were longitudinally structured using unique patient identifiers to link multiple visits per patient across the study period.

Age was treated as a quantitative variable and categorized into standardized five-year intervals to facilitate descriptive analysis and comparability with prior epidemiological studies.^{46,47}

Data Collection and Variables

All variables were specified before data analysis to minimize analytical bias. Diagnostic classifications were based on clinician-documented diagnoses recorded in the electronic health record (EHR) at each clinical encounter. ADHD diagnostic yield by specialty was operationalized as the proportion of adult ADHD diagnoses relative to the total number of unique patients seen within each specialty during the study period. This patient-based definition enabled a more interpretable comparison of diagnostic activity across outpatient services.

Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics for Windows, Version 30.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics, including frequencies and proportions, were used to summarize demographic characteristics, diagnostic patterns, comorbidity profiles and prescribing practices.

One-way analysis of variance (ANOVA) was used to compare the diagnostic yield for ADHD across outpatient specialties, using rate-based measures. Assumptions for parametric testing were assessed prior to analysis. Chi-square tests were used to examine associations among categorical variables, including demographic characteristics, diagnosis type, distribution of ADHD subtypes, presence of comorbidities, and medication prescribing patterns.

Records with missing data were excluded from specific analyses on a variable-by-variable basis, and no imputation procedures were applied. All analyses were exploratory and associative in nature; no sensitivity analyses were conducted, and no causal inferences were made. Statistical significance was defined as a two-sided P-value < 0.05.

Ethics Statement

The study was conducted in accordance with the Declaration of Helsinki. Given the retrospective nature of the study and the use of anonymized, routinely collected clinical data, the ethics committees approving the study waived the requirement for informed consent. All data were anonymized at the point of extraction and stored securely on password-protected, restricted-access systems accessible only to authorized research personnel.

Ethical approval was obtained from the Medclinic Middle East Research and Ethics Committee (MCME REC approval No. MCME.CR.371.MPAR.2024), issued on 23 October 2024. Additional regulatory approval was granted by the Dubai Health Authority through the Dubai Scientific and Research Ethics Committee (DSREC) (approval No. DSREC-02/2025_05), obtained on 12 February 2025.

Results

Study Population and Demographic Characteristics

During the study period (May 2023–August 2024), a total of 157 adult patients aged ≥ 18 years were diagnosed with attention-deficit/hyperactivity disorder (ADHD) across four outpatient specialties at Mediclinic Parkview Hospital (Table 1).

The cohort comprised 82 males (52.2%) and 75 females (47.8%). The most represented age groups were 18–19 years (24.8%) and 35–39 years (20.4%), followed by 40–44 years (16.6%) and 30–34 years (10.8%) (Figure 1).

Diagnosing Specialty and Diagnostic Hierarchy

Most ADHD diagnoses were made within Psychiatry (n=95, 61%), followed by Family Medicine (n=44, 28%), Neurology (n=16, 10%), and Internal Medicine (n=2, 1%) (Figure 2).

Table 1 Demographic and Clinical Characteristics of Adult ADHD Patients Diagnosed at MPAR (May 2023 – August 2024)

Total Patients	N = 157 (100%)
Gender	
Female	75 (47.8%)
Male	82 (52.2%)
Five-Year Age Groups ^a	
15-19 ^b	39 (24.8%)
20-24	8 (5.1%)
25-29	14 (8.9%)
30-34	17 (10.8%)
35–39	32 (20.4%)
40-44	26 (16.6%)
45-49	15 (9.6%)
50-54	6 (3.8%)
Diagnosis Type	
Primary ADHD Diagnosis without Comorbid Conditions	40 (25.5%)
Primary ADHD Diagnosis with Comorbid Conditions	21 (13.4%)
Secondary ADHD with Primary Comorbid Conditions	96 (61.1%)
Diagnosing Specialty	
Psychiatry	95 (60.5%)
Family Medicine	44 (28.0%)
Neurology	16 (10.2%)
Internal Medicine	2 (1.3%)
ADHD Cases per Diagnosis Year	
2023	80 (51.0%)
2024	77 (49.0%)

Notes: ^aThe age group classifications were adapted from the World Health Organization and Statistics Canada;^{46,47} ^bOnly patients above 18 years old were considered as per study inclusion criteria.

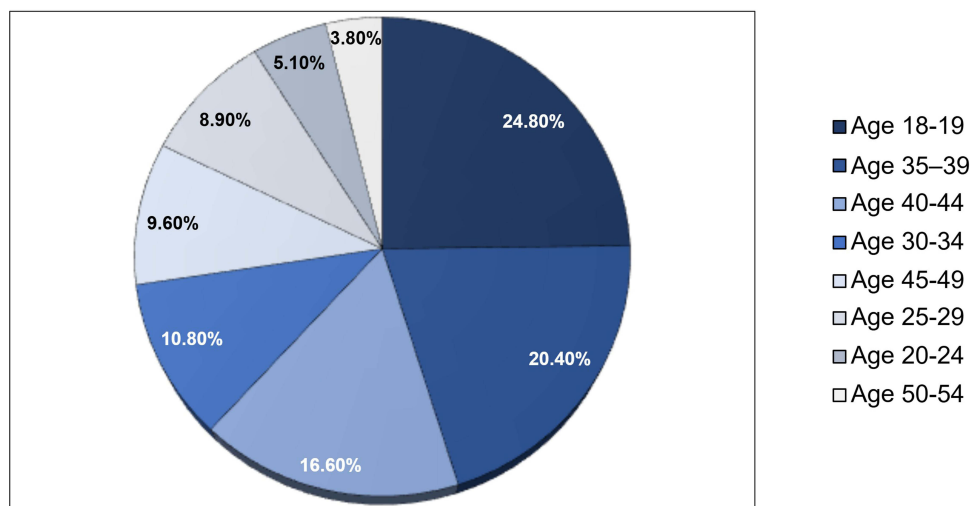


Figure 1 Age Groups Distribution of Adult ADHD Patients Diagnosed at MPAR (May 2023 – August 2024).

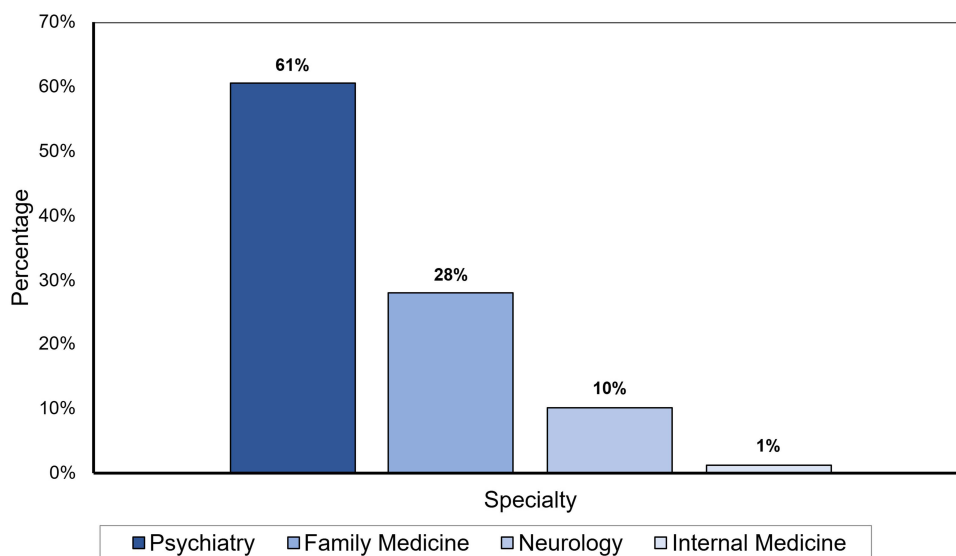


Figure 2 Distribution of Adult ADHD Diagnoses by Outpatient Specialty at MPAR.

Overall, 61 patients (38.9%) had ADHD documented as a primary diagnosis, whereas 96 patients (61.1%) had ADHD recorded as a secondary diagnosis alongside other psychiatric or neurological conditions.

Temporal Patterns of Adult ADHD Diagnoses

The distribution of adult ADHD diagnoses was closely comparable across calendar years, with 80 cases (51%) identified in 2023 and 77 cases (49%) in 2024. Monthly case counts varied within each year, with higher counts in May and June of both years and lower counts in December 2023 and August 2024 in Dubai. Overall, monthly diagnosis counts showed temporal variability without evidence of sustained increases or decreases. Monthly data are presented as absolute counts (Figure 3).

ADHD Subtypes and Psychiatric Comorbidities

The distribution of ADHD subtypes and associated psychiatric comorbidities among the 157 adult patients is summarized in Table 2. Overall, 40 patients (25.5%) were diagnosed with primary ADHD without comorbid conditions, with the predominantly

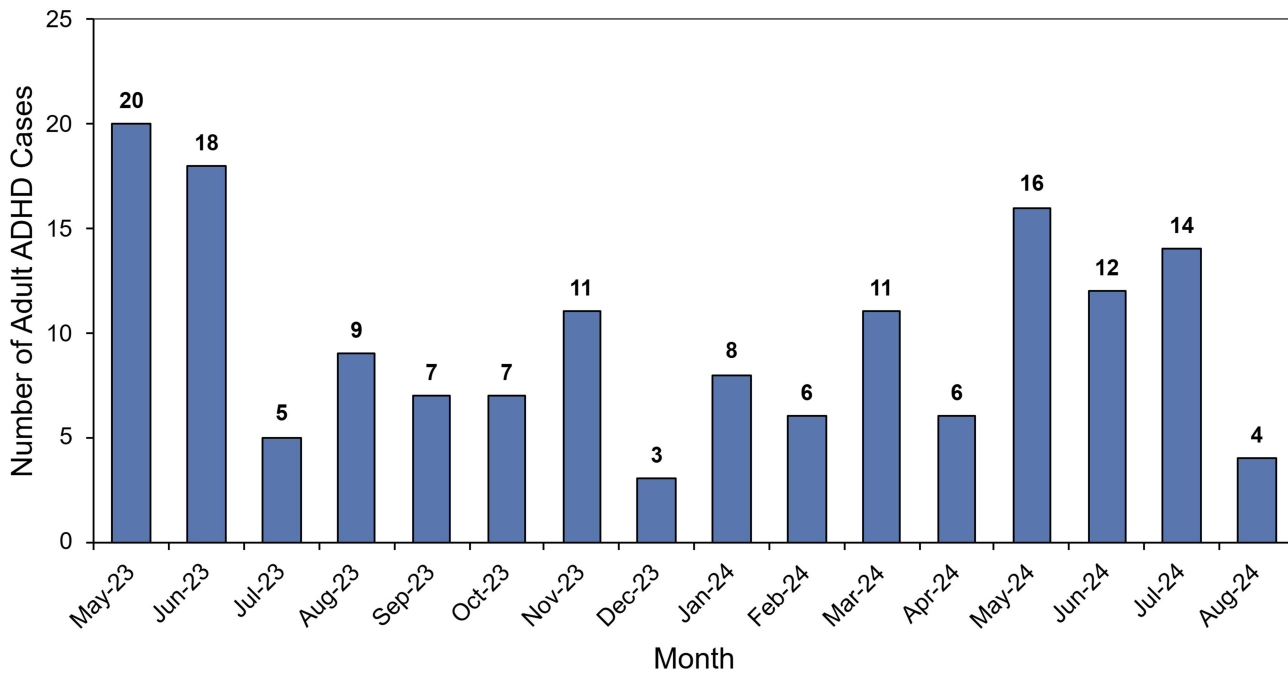


Figure 3 Monthly Counts of Adult ADHD Diagnoses at MPAR (May 2023 – August 2024).

inattentive subtype being the most frequently documented. An additional 21 patients (13.4%) had a primary ADHD diagnosis with comorbid generalized anxiety disorder (GAD), most commonly in combination with the combined or inattentive subtypes.

The majority of cases (n = 96, 61.1%) were classified as secondary ADHD with primary comorbid psychiatric conditions. Within this group, generalized anxiety disorder (GAD) and major depressive disorder (MDD) were the most frequently recorded co-occurring diagnoses.

Across the cohort, inattentive and unspecified ADHD subtypes were more commonly observed than the hyperactive subtype, particularly among patients with comorbid psychiatric conditions. This pattern of ADHD subtypes and comorbidity categories features the clinical heterogeneity and diagnostic complexity of adult ADHD presentations.

Table 2 Distribution of ADHD Diagnoses and Comorbid Conditions Among Adult Patients

Total Patients	N = 157 (100%)
Primary ADHD Diagnosis without Comorbid Conditions	40 (25.5%)
Attention-deficit hyperactivity disorder, combined type	9 (5.7%)
Attention-deficit hyperactivity disorder, predominantly hyperactive type	2 (1.3%)
Attention-deficit hyperactivity disorder, predominantly inattentive type	16 (10.2%)
Attention-deficit hyperactivity disorder, unspecified type	13 (8.3%)
Primary ADHD Diagnosis with Comorbid Conditions	21 (13.4%)
Attention-deficit hyperactivity disorder, combined type, with generalized anxiety disorder (GAD)	9 (5.7%)
Attention-deficit hyperactivity disorder, predominantly inattentive type, with generalized anxiety disorder	8 (5.1%)
Attention-deficit hyperactivity disorder, unspecified type, with generalized anxiety disorder	4 (2.6%)
Secondary ADHD with Primary Comorbid Conditions	96 (61.1%)
Generalized anxiety disorder with attention-deficit hyperactivity disorder, combined type	12 (7.6%)

(Continued)

Table 2 (Continued).

Total Patients	N = 157 (100%)
Generalized anxiety disorder with attention-deficit hyperactivity disorder, predominantly inattentive type	17 (10.8%)
Major depressive disorder with attention-deficit hyperactivity disorder, predominantly inattentive type	8 (5.1%)
Generalized anxiety disorder with attention-deficit hyperactivity disorder, unspecified type	15 (9.6%)
Major depressive disorder with attention-deficit hyperactivity disorder, unspecified type	5 (3.2%)
Migraine with attention-deficit hyperactivity disorder, unspecified type	3 (1.9%)
Other diagnoses with attention-deficit hyperactivity disorder, unspecified type	36 (22.9%)

Notes: Bold text denotes the main diagnostic categories (primary ADHD without comorbidity, primary ADHD with comorbidity, and secondary ADHD with primary comorbid conditions), while non-bold entries represent the detailed subtypes and specific diagnostic combinations within each category.

ADHD Medication Prescribing Patterns

Across the cohort, a total of 509 medications were prescribed, reflecting both ADHD-specific treatments and medications for comorbid conditions. Methylphenidate-based formulations accounted for 234 prescriptions (46.0%), including Concerta (31.2%) and Ritalin (14.7%). Non-stimulant FDA-approved ADHD medication, specifically atomoxetine (1.8%), was prescribed infrequently, while off-label psychotropic medications, such as bupropion (4.1%), were used primarily for the management of associated psychiatric comorbidities rather than as first-line ADHD treatments. (Table 3).

Statistical Analyses

One-way analysis of variance demonstrated a statistically significant difference in ADHD diagnostic yield across outpatient specialties ($F = 32.96$, $P < 0.001$), indicating variation in diagnostic rates between Psychiatry, Family Medicine, Neurology, and Internal Medicine.

Chi-square analyses showed no statistically significant associations between ADHD diagnosis type and gender ($\chi^2 = 0.89$, $P = 0.640$), age group ($\chi^2 = 6.72$, $P = 0.945$), or diagnosis year ($\chi^2 = 0.03$, $P = 0.984$). Similarly, the presence of comorbidity did not differ significantly by gender ($\chi^2 = 0.05$, $P = 0.824$) or age group ($\chi^2 = 2.62$, $P = 0.918$).

In contrast, significant differences were observed in the distribution of ADHD subtypes ($\chi^2 = 85.82$, $P < 0.001$) and comorbidity categories ($\chi^2 = 77.84$, $P < 0.001$), with inattentive and unspecified subtypes occurring more frequently than the hyperactive subtype, and anxiety-related disorders being the most commonly documented comorbidities. Comorbidity presence was significantly associated with diagnosis type, with psychiatric comorbidities more frequently observed among patients with secondary ADHD diagnoses ($\chi^2 = 157.00$, $P < 0.001$). In addition, medication prescription categories differed significantly ($\chi^2 = 314.21$, $P < 0.001$), with methylphenidate-based formulations accounting for the largest proportion of prescriptions. (Table 4) summarizes all inferential statistical analyses.

Table 3 Medication Prescribing Patterns Among Adults with ADHD

Medication Class	Medication	N = 509 (100%)
Stimulants (ADHD-FDA approved)	Concerta® (Methylphenidate)	159 (31.2%)
	Ritalin® (Methylphenidate)	75 (14.7%)
	Vyvanse® (Lisdexamfetamine)	1 (0.2%)
Non-stimulant (ADHD-FDA approved)	Strattera® Atomoxetine	9 (1.8%)
Other psychotropic medications (off-label / comorbidity-related)	Bupropion	21 (4.1%)
Other medications	Medications for psychiatric or medical comorbidities	244 (48.0%)

Abbreviations: ADHD, Attention-Deficit Hyperactivity Disorder; FDA, The US Food and Drug Administration.

Table 4 Summary of Statistical Tests Examining Demographic, Diagnostic, and Comorbidity Patterns in MPAR Adult ADHD Data (May 2023–August 2024)

Comparison	Statistic (F / χ^2)	P-value*
ADHD Diagnostic Yields Across Specialties	F = 32.96	<0.001*
Gender vs. ADHD Diagnosis Type	$\chi^2 = 0.89$	0.640
Age Group vs. ADHD Diagnosis Type	$\chi^2 = 6.72$	0.945
Diagnosis Year vs. ADHD Diagnosis Type	$\chi^2 = 0.03$	0.984
Gender vs. Comorbidity Presence	$\chi^2 = 0.05$	0.824
Age Group vs. Comorbidity Presence	$\chi^2 = 2.62$	0.918
ADHD Subtype Distribution	$\chi^2 = 85.82$	<0.001*
Comorbidity Category Distribution	$\chi^2 = 77.84$	<0.001*
Diagnosis Type (Primary/Secondary) vs. Comorbidity Presence	$\chi^2 = 157.00$	<0.001*
Medication Prescription Distribution	$\chi^2 = 314.21$	<0.001*

Note: *Statistically significant values at $P < 0.05$ are highlighted in bold style.

Discussion

This retrospective study, conducted at Mediclinic Parkview Hospital (MPAR), United Arab Emirates (UAE), provided an overview of adult attention-deficit/hyperactivity disorder (ADHD) diagnostic and prescribing practices within a tertiary outpatient setting, interpreted within the context of existing regional and international literature. Importantly, the findings highlighted context-specific patterns across specialties within the UAE healthcare system, which remain underrepresented in the literature.

Adult ADHD diagnostic yield varied significantly across outpatient specialties, with Psychiatry demonstrating the highest rate-based diagnostic yield, followed by Family Medicine, Neurology and Internal Medicine. This pattern is consistent with global observations identifying Psychiatry as the primary setting for adult ADHD diagnosis, while highlighting under-recognition in non-psychiatric specialties, particularly in the presence of comorbid or atypical presentations. This variation should be interpreted in the context of widely reported adult ADHD prevalence estimates ranging from 1.13% to over 30%, which reflect variability in recognition and diagnostic practices across different healthcare settings.^{48,49} The specialty-specific diagnostic yields observed at MPAR fall toward the lower end of expected detection in general healthcare contexts, reinforcing concerns about suboptimal knowledge and underdiagnosis of adult ADHD outside specialized mental health services.^{50,51} Contributing factors may include referral pathways, clinician awareness, insurance coverage limitations and stigma surrounding adult ADHD in the region.³⁹

In addition, although overall case numbers were closely comparable across calendar years, monthly diagnosis counts varied over time, with recurrent peaks in late spring and lower counts observed during the summer months and toward the end of the calendar year, potentially reflecting reduced outpatient attendance in the UAE during school summer breaks and broader seasonal variation in healthcare utilization rather than a sustained directional pattern.

The cohort demonstrated a slight male predominance, consistent with existing literature reporting higher diagnosis rates among males.⁵² Younger adults represented a substantial proportion of diagnosed cases.^{11,37} Statistical analysis showed no significant associations between ADHD diagnosis type and gender or age group. In addition, no significant gender- or age-based differences in comorbidity prevalence were observed. These findings suggest that demographic characteristics alone did not drive diagnostic patterns within this cohort.

A substantial proportion of patients had ADHD documented as a secondary diagnosis in the presence of psychiatric comorbidities, most commonly anxiety and depressive disorders. This diagnostic hierarchy reflects challenges consistently reported in adult ADHD literature, where overlapping symptomatology and childhood-centric diagnostic frameworks may delay or obscure ADHD recognition. Similar patterns have been described across multiple international

settings, including reports from adult ADHD clinics in neighboring Gulf countries, where psychiatric comorbidities were present in the majority of cases.⁵³

The observed association between diagnosis type and comorbidity presence reflects patterns in clinical classification rather than an independent relationship, highlighting the importance of comprehensive diagnostic evaluations in adult populations. The predominance of inattentive and unspecified ADHD subtypes, particularly among patients with psychiatric comorbidities, further illustrates the heterogeneity of adult ADHD presentations and supports prior evidence that non-hyperactive symptom profiles are more common in adults and may contribute to delayed recognition or misclassification.^{54–57}

Psychiatric comorbidities were highly prevalent in this cohort, with nearly three-quarters of patients presenting with at least one comorbid condition, most commonly generalized anxiety disorder and major depressive disorder.^{11,58} This finding aligns with prior evidence demonstrating that psychiatric comorbidities are common and clinically significant among adults with ADHD and contribute to increased healthcare utilization and treatment complexity.^{59,60} The marked imbalance in comorbidity categories highlights the heterogeneity of adult ADHD presentations and underscores the importance of comprehensive, technology-enabled assessment by suitably trained mental health professionals to identify co-occurring and alternative diagnoses accurately.⁶¹ In this study, the high prevalence of comorbidities directly supports the need for structured diagnostic assessment in routine clinical care.

Pharmacological treatment in this cohort was predominantly stimulant-based, with methylphenidate accounting for nearly half of all prescriptions. This prescribing pattern aligns with international clinical guidance supporting stimulants as first-line therapy for adult ADHD.¹ Non-stimulant atomoxetine was prescribed less frequently, while off-label agents such as bupropion were more commonly observed among patients with co-occurring psychiatric conditions. The statistically significant difference observed in medication distribution reflects the central role of stimulant therapy while also reflecting the complexity of pharmacological management in multimorbid adult ADHD populations.^{62–65}

A total of 509 medications were prescribed to 157 patients, corresponding to an average of approximately 3.2 medications per patient, indicating frequent use of combination therapy, medication adjustments, and pharmacological management of comorbid conditions. These findings highlight the multifaceted nature of pharmacological management in adult ADHD, particularly in the presence of comorbid conditions, and support the need for individualized and flexible treatment strategies.^{66–70}

Medication availability should be considered when interpreting these findings. Previously documented supply disruptions at the study institution may have intermittently limited access to high-demand stimulant medications, including methylphenidate, potentially influencing prescribing continuity and treatment adherence during the study period.⁷¹

The diagnostic and prescribing patterns observed at MPAR mirror broader regional trends within the Middle East and North Africa, where adult ADHD diagnosis and management vary across healthcare systems. The concentration of diagnoses within psychiatric services and reliance on stimulant pharmacotherapy highlight the influence of local referral pathways, healthcare infrastructure, and cultural perceptions of ADHD.^{72,73} These findings support the need for standardized, nationally relevant clinical pathways for adult ADHD within general outpatient services in the region.³⁸

The high prevalence of psychiatric comorbidities and the intensity of pharmacological treatment observed in this cohort suggest increased healthcare resource utilization. This finding is consistent with global evidence linking adult ADHD, particularly when accompanied by psychiatric comorbidity, to higher direct and indirect healthcare costs.²⁹ Investment in integrated care models and in evaluating the cost-effectiveness of adult ADHD interventions may help mitigate the long-term economic burden.⁷⁴

This study represents one of the few UAE-specific retrospective analyses of adult ADHD and benefits from real-world clinical data captured across multiple outpatient specialties within a tertiary care hospital. However, the retrospective design limited causal inference and relied on the completeness and accuracy of electronic health record documentation. The monthly variation analysis and the association between diagnosis type and comorbidity should be interpreted cautiously, given the limited observations and the inherent relationship between these variables, and are presented as descriptive findings. In addition, the diagnostic yield estimates may be influenced by differences in patient revisit frequency across specialties, which were not adjusted for in the analysis. The single-center setting may limit generalizability, and patient-reported outcomes, symptom severity measures, and objective assessments of treatment adherence were not available.

Future studies should employ multicenter designs across diverse healthcare settings in the UAE to improve generalizability and enable comparative analyses of adult ADHD diagnostic pathways and prescribing practices. Prospective longitudinal studies incorporating standardized diagnostic instruments, symptom severity measures, and patient-reported outcomes would allow evaluation of diagnostic stability, treatment effectiveness, and long-term adherence. Integration of healthcare utilization data, including appointment attendance and follow-up patterns, may clarify the influence of system-level and seasonal factors on diagnostic activity. Given the evolving role of artificial intelligence (AI) in clinical medicine and diagnosis, future research should also investigate how AI-assisted decision support systems, predictive models, and natural language processing tools could enhance the accuracy and efficiency of adult ADHD screening and diagnostic workflows.⁷⁵ In addition, studies assessing medication availability, supply chain disruptions, and their impact on prescribing continuity are warranted to contextualize treatment patterns in real-world settings better. Finally, economic evaluations examining the cost-effectiveness of integrated and multidisciplinary care models for adults with ADHD, particularly those with psychiatric comorbidities, would inform national policy development and clinical guideline refinement.

Conclusion

This retrospective analysis of adult ADHD in a single-center tertiary hospital in the United Arab Emirates demonstrated marked variation in diagnostic yield across outpatient specialties, with diagnoses occurring predominantly within psychiatric services and frequently in the presence of psychiatric comorbidity. ADHD was more often documented as a secondary diagnosis rather than as a standalone condition, underscoring the clinical complexity of adult presentations and the potential for under-recognition outside specialist mental health settings. Pharmacological management was largely stimulant-based, with methylphenidate formulations accounting for the largest proportion of prescriptions, alongside substantial pharmacological treatment of comorbid conditions. Collectively, these findings, within the limitations of the study design, highlight the need for refined, nationally relevant clinical pathways that support standardized assessment, cross-specialty collaboration, and integrated management of adult ADHD within the UAE healthcare system.

AI Use Statement

The authors disclose the use of generative AI tools (ChatGPT-5.2 and Grammarly) to support language editing and improve presentation clarity. All AI-assisted outputs were critically reviewed by the authors, who take full responsibility for the accuracy, integrity, and interpretation of the study.

Abbreviations

ADHD, attention-deficit/hyperactivity disorder; UAE, United Arab Emirates; ICD-10, International Classification of Diseases, Tenth Revision; ANOVA, analysis of variance; EHR, electronic health record; STROBE, Strengthening the Reporting of Observational Studies in Epidemiology; JCI, Joint Commission International; MPAR, Mediclinic Parkview Hospital; GAD, generalized anxiety disorder; MDD, major depressive disorder; FDA, US Food and Drug Administration; AI, artificial intelligence.

Data Sharing Statement

The data supporting the findings of this study can be obtained from the corresponding author upon reasonable request.

Ethics Approval and Consent to Participate

The study adhered to the principles of the Declaration of Helsinki; due to its retrospective design and use of anonymized routinely collected clinical data, informed consent was waived by the approving ethics committees, with all data anonymized at extraction and securely stored on password-protected, restricted-access systems accessible only to authorized research staff, and ethical approval was obtained from the Mediclinic Middle East Research and Ethics Committee (MCME REC No. MCME.CR.371.MPAR.2024; 23 October 2024) with additional approval from the Dubai Health Authority's Dubai Scientific and Research Ethics Committee (DSREC No. DSREC-02/2025_05; 12 February 2025).

Acknowledgments

The authors gratefully acknowledge Mediclinic Parkview Hospital, Mediclinic Middle East, for enabling and supporting the conduct of this retrospective study and for facilitating access to the required data. The authors also extend their sincere appreciation to Mohammed Bin Rashid University of Medicine and Health Sciences (MBRU) for providing academic support, a stimulating research environment, and a strong institutional commitment to advancing clinical research, innovation, and medical education in the United Arab Emirates.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

Funding

This research received no external funding.

Disclosure

The authors report no conflicts of interest in this work.

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. 5th ed. Arlington, VA: Booksmith Publishing LLC; 2013.
2. Kooij JJS, Bijlenga D, Salerno L, et al. Updated European consensus statement on diagnosis and treatment of adult ADHD. *Eur Psychiatry*. 2019;56(1):14–34. doi:10.1016/j.eurpsy.2018.11.001
3. Asherson P, Balazs J, Bitter I, et al. Attention deficit hyperactivity disorder in adults: from research to clinical practice. In: Fiorillo A, Falkai P, Gorwood P, editors. *Mental Health Research and Practice: From Evidence to Experience*. Cambridge University Press; 2024:135–157.
4. Breda V, Rohde LA, Menezes AMB, et al. The neurodevelopmental nature of attention-deficit hyperactivity disorder in adults. *Br J Psychiatry*. 2021;218(1):43–50. doi:10.1192/bjp.2020.200
5. Buitelaar JK, Kan CC, Asherson P. *ADHD in Adults: Characterization, Diagnosis, and Treatment*. New York, NY: Cambridge University Press; 2011.
6. Retz W, Klein RG. *Attention Deficit Hyperactivity Disorder (ADHD) in Adults*. Basel (Switzerland): S. Karger AG; 2010.
7. Hechtman L. *Attention Deficit Hyperactivity Disorder: Adult Outcome and Its Predictors*. New York, NY: Oxford University Press; 2016.
8. Caci H, Asherson P, Donfrancesco R, et al. Daily life impairments associated with childhood/adolescent attention-deficit/hyperactivity disorder as recalled by adults: results from the European lifetime impairment survey. *CNS Spectr*. 2015;20(2):112–121. doi:10.1017/S1092852914000078
9. Faraone SV, Biederman J, Mick E. The age-dependent decline of attention deficit hyperactivity disorder: a meta-analysis of follow-up studies. *Psychol Med*. 2006;36(2):159–165. doi:10.1017/S003329170500471X
10. Kessler RC, Green JG, Adler LA, et al. Structure and diagnosis of adult attention-deficit/hyperactivity disorder: analysis of expanded symptom criteria from the adult ADHD clinical diagnostic scale. *Arch Gen Psychiatry*. 2010;67(11):1168–1178. doi:10.1001/archgenpsychiatry.2010.146
11. Alharbi N, Alotaibi KF, Althaqel GK, et al. Adult attention deficit hyperactivity disorder (ADHD) among residents of Saudi Arabia: a cross-sectional study. *Eur Rev Med Pharmacol Sci*. 2023;27(22):10935–10943. doi:10.26355/eurrev_202311_34461
12. Asherson P, Akehurst R, Kooij JJ, et al. Under diagnosis of adult ADHD: cultural influences and societal burden. *J Atten Disord*. 2012;16(5 Suppl):20s–38s. doi:10.1177/1087054711435360
13. Schneider BC, Schöttle D, Hottenrott B, Gallinat J, Moritz S. Assessment of adult ADHD in clinical practice: four letters—40 opinions. *J Atten Disord*. 2019;27(9):1051–1061. doi:10.1177/1087054719879498
14. Faraone SV, Spencer TJ, Montano CB, Biederman J. Attention-deficit/hyperactivity disorder in adults: a survey of current practice in psychiatry and primary care. *Arch Intern Med*. 2004;164(11):1221–1226. doi:10.1001/archinte.164.11.1221
15. Fayyad J, Sampson NA, Hwang I, et al. The descriptive epidemiology of DSM-IV adult ADHD in the World Health Organization world mental health surveys. *Atten Defic Hyperact Disord*. 2017;9(1):47–65. doi:10.1007/s12402-016-0208-3
16. Bachmann CJ, Philipsen A, Hoffmann F. ADHD in Germany: trends in diagnosis and pharmacotherapy. *Dtsch Arztebl Int*. 2017;114(9):141–148. doi:10.3238/arztebl.2017.0141
17. Ginsberg Y, Quintero J, Anand E, Casillas M, Upadhyaya HP. Underdiagnosis of attention-deficit/hyperactivity disorder in adult patients: a review of the literature. *Prim Care Companion CNS Disord*. 2014;16(3). doi:10.4088/PCC.13r01600
18. Barkley RA, Murphy KR, Fischer M. *ADHD in Adults: What the Science Says*. New York, NY: Guilford Publications; 2008.
19. Al-Timimi SJ, Jamil NF. Making sense of adult attention deficit hyperactivity disorder (A-ADHD). *Arab J Psychiatry*. 2021;32(2):124–130. doi:10.12816/0059212
20. Schoeman R, Voges T. Attention-deficit hyperactivity disorder stigma: the silent barrier to care. *S Afr J Psychiatr*. 2022;28:1865. doi:10.4102/sajpsy.2021.v28i0.1865
21. Watters C, Adamis D, McNicholas F, Gavin B. The impact of attention deficit hyperactivity disorder (ADHD) in adulthood: a qualitative study. *Ir J Psychol Med*. 2018;35(3):173–179. doi:10.1017/ipm.2017.21

22. French B, Sayal K, Daley D. Barriers and facilitators to understanding of ADHD in primary care: a mixed-method systematic review. *Eur Child Adolesc Psychiatry*. 2019;28(8):1037–1064. doi:10.1007/s00787-018-1256-3
23. French B, Perez Vallejos E, Sayal K, Daley D. Awareness of ADHD in primary care: stakeholder perspectives. *BMC Fam Pract*. 2020;21(1):45. doi:10.1186/s12875-020-01112-1
24. Bjerrum MB, Pedersen PU, Larsen P. Living with symptoms of attention deficit hyperactivity disorder in adulthood: a systematic review of qualitative evidence. *JBI Database System Rev Implement Rep*. 2017;15(4):1080–1153. doi:10.11124/jbisrir-2017-003357
25. Demirkan A, Semiz U. Investigating ADHD symptoms and sleep disturbances in young adults: a cross-sectional study. *Nat Sci Sleep*. 2025;17:1615–1627. doi:10.2147/NSS.S537569
26. Jain AR, Jain AS, Montano ACB. Addressing diagnosis and treatment gaps in adults with attention-deficit/hyperactivity disorder. *Prim Care Companion CNS Disord*. 2017;19(5):17nr02153. doi:10.4088/PCC.17nr02153
27. Hodgkins P, Arnold LE, Shaw M, et al. A systematic review of global publication trends regarding long-term outcomes of ADHD. *Front Psychiatry*. 2012;2:84. doi:10.3389/fpsy.2011.00084
28. Barkley RA. *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*. 4th ed. New York, NY: Guilford Publications; 2014.
29. Schein J, Adler LA, Childress A, et al. Economic burden of attention-deficit/hyperactivity disorder among adults in the United States: a societal perspective. *J Manag Care Spec Pharm*. 2022a;28(2):168–179. doi:10.18553/jmcp.2021.21290
30. Libutzi B, May M, Gleitz M, et al. Disease burden and direct medical costs of incident adult ADHD: a retrospective longitudinal analysis based on German statutory health insurance claims data. *Eur Psychiatry*. 2020;63(1):e86. doi:10.1192/j.eurpsy.2020.84
31. Daley D, Jacobsen RH, Lange AM, Sørensen A, Walldorf J. *Costing Adult Attention Deficit Hyperactivity Disorder: Impact on the Individual and Society*. New York, NY: Oxford University Press; 2015.
32. May T, Aizenstros A, Aizenstros J. Characteristics of adults with attention deficit hyperactivity disorder consecutively referred to an Australian private psychiatric clinic. *Aust Psychologist*. 2022;57(2):117–127. doi:10.1080/00050067.2021.1969211
33. Schein J, Childress A, Adams J, et al. Treatment patterns among adults with attention-deficit/hyperactivity disorder in the United States: a retrospective claims study. *Curr Med Res Opin*. 2021;37(11):2007–2014. doi:10.1080/03007995.2021.1968814
34. Simon V, Czobor P, Bitter I. Is ADHD severity in adults associated with the lifetime prevalence of comorbid depressive episodes and anxiety disorders? *Eur Psychiatry*. 2013;28(5):308–314. doi:10.1016/j.eurpsy.2012.05.002
35. Zalsman G, Shilton T. Adult ADHD: a new disease? *Int J Psychiatry Clin Pract*. 2016;20(2):70–76. doi:10.3109/13651501.2016.1149197
36. Bergey MR, Filipe AM, Conrad P, Singh I. *Global Perspectives on ADHD: Social Dimensions of Diagnosis and Treatment in Sixteen Countries*. Baltimore, MD: Johns Hopkins University Press; 2018.
37. Al-Yateem N, Slewa-Younan S, Halimi A, et al. Prevalence of undiagnosed attention deficit hyperactivity disorder (ADHD) symptoms in the young adult population of the United Arab Emirates: a national cross-sectional study. *J Epidemiol Glob Health*. 2024;14(1):45–53. doi:10.1007/s44197-023-00167-4
38. El Hayek G, Saab D, Farhat C, Krayem Z, Karam E. Adult ADHD in the Arab World: a review. *Arch Psychol*. 2019;3. doi:10.31296/aop.v3i1.115
39. Maalouf F, Alamiri B, Atweh S, et al. Mental health research in the Arab region: challenges and call for action. *The Lancet Psychiatry*. 2019;6(11):961–966. doi:10.1016/S2215-0366(19)30124-5
40. Alansari A, Jahrami H. Mapping the research activity on psychiatric disorders in Bahrain: a 40-year analysis. *Bahrain Med Bulletin*. 2021;43:376.
41. Alkhateeb JM, Alhadidi MS. ADHD research in Arab Countries: a systematic review of literature. *J Atten Disord*. 2019;23(13):1531–1545. doi:10.1177/1087054715623047
42. Alhraiwiil NJ, Ali A, Househ MS, Al-Shehri AM, El-Metwally AA. Systematic review of the epidemiology of attention deficit hyperactivity disorder in Arab countries. *Neurosciences*. 2015;20(2):137–144. doi:10.17712/nsj.2015.2.20140678
43. AlOmar RS, AlShamlan NA, Al-Johani WM, et al. Adult ADHD positive screening and sibship, birth order and academic achievement: implications for Epidemiologists and Physicians in the Kingdom of Saudi Arabia. *Psychol Res Behav Manag*. 2023;16:4069–4081. doi:10.2147/prbm.S426715
44. von Elm E, Altman DG, Egger M, Pocock SJ, Gøtzsche PC, Vandenbroucke JP. The strengthening the reporting of observational studies in epidemiology (STROBE) statement: guidelines for reporting observational studies. *Lancet*. 2007;370(9596):1453–1457. doi:10.1016/S0140-6736(07)61602-X
45. Mediclinic Middle East. Mediclinic Parkview Hospital. 2025. Available from: <https://www.mediclinic.ae/en/parkview-hospital/home.html>. Accessed December 22, 2025.
46. World Health Organization. Age group codelist. 2013. Available from: <https://apps.who.int/gho/data/node.searo-metadata>. Accessed November 28, 2025.
47. Statistics Canada. Age categories, five-year age groups. 2024. Available from: <https://www.statcan.gc.ca/en/concepts/definitions/age1>. Accessed November 28, 2025.
48. Salama R, Matar T, Ammar A, et al. Prevalence and risk factors of adult attention deficit hyperactivity disorder in university students: a study from the United Arab Emirates. *Narra J*. 2025;5(2):e1950. doi:10.52225/narra.v5i2.1950
49. Bedawi RM, Al-Farsi Y, Mirza H, et al. Prevalence and clinical profile of adults with ADHD attending a tertiary care hospital for five years. *Int J Environ Res Public Health*. 2024;21(5):566. doi:10.3390/ijerph21050566
50. Al-Ahmari AA, Bharti RK, Al-Shahrani MS, Alharthi MH, Alqarni HM, Alshehri HM. Knowledge, attitude, and performance of primary healthcare physicians in Aseer Region, Saudi Arabia about attention deficit hyperactivity disorder. *J Family Commun Med*. 2018;25(3):194–198. doi:10.4103/jfcm.JFCM_120_17
51. Loskutova NY, Waterman J, Callen E, Staton EW, Bullard E, Shields J. Knowledge, attitudes, and practice patterns of health professionals toward medical and non-medical stimulant use by young adults. *J Am Board Fam Med*. 2020;33(1):59. doi:10.3122/jabfm.2020.01.190071
52. Faheem M, Akram W, Akram H, Khan MA, Siddiqui FA, Majeed I. Gender-based differences in prevalence and effects of ADHD in adults: a systematic review. *Asian J Psychiatry*. 2022;75:103205. doi:10.1016/j.ajp.2022.103205
53. Srour A, Abdallah O, Eltorki YH, et al. Developing the first data-informed adult attention deficit hyperactivity disorder service in Qatar. *Cureus*. 2025;17(1):e77305. doi:10.7759/cureus.77305
54. Newcorn JH, Weiss M, Stein MA. The complexity of ADHD: diagnosis and treatment of the adult patient with comorbidities. *CNS Spectr*. 2007;12(S12):1–16. doi:10.1017/S1092852900026158

55. Sobanski E, Brüggemann D, Alm B, et al. Subtype differences in adults with attention-deficit/hyperactivity disorder (ADHD) with regard to ADHD-symptoms, psychiatric comorbidity and psychosocial adjustment. *Eur Psychiatry*. 2008;23(2):142–149. doi:10.1016/j.eurpsy.2007.09.007
56. Klassen LJ, Katzman MA, Chokka P. Adult ADHD and its comorbidities, with a focus on bipolar disorder. *J Affect Disord*. 2010;124(1–2):1–8. doi:10.1016/j.jad.2009.06.036
57. Fischer AG, Bau CH, Grevet EH, et al. The role of comorbid major depressive disorder in the clinical presentation of adult ADHD. *J Psychiatr Res*. 2007;41(12):991–996. doi:10.1016/j.jpsychires.2006.09.008
58. Szaniawska M, Kokoszka A. Prevalence of ADHD among nonpsychotic patients of day-care centers and comparison of psychiatric comorbidities among persons with and without ADHD: a pilot study. *J Clin Med*. 2025;14(4):1153. doi:10.3390/jcm14041153
59. Schein J, Cloutier M, Gauthier-Loiselle M, et al. Health care resource utilization and costs associated with psychiatric comorbidities in adult patients with attention-deficit/hyperactivity disorder. *J Manag Care Spec Pharm*. 2024;30(6):588–598. doi:10.18553/jmcp.2024.30.6.588
60. Mirza H, Al-Huseini S, Al-Jamoodi S, et al. Socio-demographic and clinical profiles of adult attention deficit hyperactivity disorder patients in a university hospital in Oman. *Sultan Qaboos Univ Med J*. 2022;22(2):206–211. doi:10.18295/squmj.5.2021.104
61. McGuigan LM. Explaining heterogeneity: identifying subgroups of adult attention-deficit/hyperactivity disorder. Order No. 31146629. Marquette University; 2024. Available from: <https://www.proquest.com/dissertations-theses/explaining-heterogeneity-identifying-subgroups/docview/3039869301/se-2>. Accessed January 02, 2026.
62. Renoux C, Shin JY, Dell'Aniello S, Fergusson E, Suissa S. Prescribing trends of attention-deficit hyperactivity disorder (ADHD) medications in UK primary care, 1995-2015. *Br J Clin Pharmacol*. 2016;82(3):858–868. doi:10.1111/bcp.13000
63. Morkem R, Patten S, Queenan J, Barber D. Recent trends in the prescribing of ADHD medications in Canadian primary care. *J Atten Disord*. 2017;24(2):301–308. doi:10.1177/1087054717720719
64. Radley A, Melia B, Maciver D, Rutherford M, Boilson M. An analysis of prescribing data in attention-deficit hyperactivity disorder for adolescents and adults in Scotland. *BJPsych Open*. 2024;10(5):e143. doi:10.1192/bjo.2024.722
65. Al Kiyumi O, Al-Mahrouqi T, Al-Huseini S, et al. Clinical features and comparative treatment outcomes of atomoxetine and methylphenidate in Omani adults with ADHD. *Oman Med J*. 2025;40(3):e752. doi:10.5001/omj.2025.73
66. Schein J, Childress A, Cloutier M, et al. Reasons for treatment changes in adults with attention-deficit/hyperactivity disorder: a chart review study. *BMC Psychiatry*. 2022b;22(1):377. doi:10.1186/s12888-022-04016-9
67. Williams OC, Prasad S, McCrary A, et al. Adult attention deficit hyperactivity disorder: a comprehensive review. *Ann Med Surg Lond*. 2023;85(5):1802–1810. doi:10.1097/MS9.0000000000000631
68. Fredriksen M, Peleikis DE. Long-term pharmacotherapy of adults with attention deficit hyperactivity disorder: a literature review and clinical study. *Basic Clin Pharmacol Toxicol*. 2016;118(1):23–31. doi:10.1111/bcpt.12477
69. Biederman J, DiSalvo M, Green A, et al. Rates of switching stimulants in consecutively referred medication naïve adults with ADHD. *Acta Psychiatr Scand*. 2021;144(6):626–634. doi:10.1111/acps.13370
70. Liman C, Schein J, Wu A, et al. Real world analysis of treatment change and response in adults with attention-deficit/hyperactivity disorder (ADHD) alone and with concomitant psychiatric comorbidities: results from an electronic health record database study in the United States. *BMC Psychiatry*. 2024;24(1):618. doi:10.1186/s12888-024-05994-8
71. Sallam M, Oliver A, Allam D, Kassem R, Damani M. Addressing drug shortages at mediclinic parkview hospital: a five-year study of challenges, impact, and strategies. *Cureus*. 2024;16(12):e76377. doi:10.7759/cureus.76377
72. Alsafar FA, Alsaad AJ, Albukhaytan WA. Prevalence of adult attention deficit hyperactivity disorder (ADHD) among medical students in the Eastern Province of Saudi Arabia. *Saudi Med J*. 2024;45(4):397–404. doi:10.15537/smj.2024.45.4.20230841
73. Lewczuk K, Marcowski P, Wizla M, et al. Cross-cultural adult ADHD assessment in 42 countries using the adult ADHD self-report scale screener. *J Atten Disord*. 2024;28(4):512–530. doi:10.1177/10870547231215518
74. Daley D, Jacobsen RH, Lange AM, Sørensen A, Walldorf J. The economic burden of adult attention deficit hyperactivity disorder: a sibling comparison cost analysis. *Eur Psychiatry*. 2019;61:41–48. doi:10.1016/j.eurpsy.2019.06.011
75. Sallam M, Snygg J, Allam D, Kassem R, Damani M. Artificial intelligence in clinical medicine: a SWOT analysis of AI progress in diagnostics, therapeutics, and safety. *J Innov Med Res*. 2025;4(3):1–20. doi:10.63593/JIMR.2788-7022.2025.06.001

Neuropsychiatric Disease and Treatment

Publish your work in this journal

Neuropsychiatric Disease and Treatment is an international, peer-reviewed journal of clinical therapeutics and pharmacology focusing on concise rapid reporting of clinical or pre-clinical studies on a range of neuropsychiatric and neurological disorders. This journal is indexed on PubMed Central, the 'PsyncINFO' database and CAS, and is the official journal of The International Neuropsychiatric Association (INA). The manuscript management system is completely online and includes a very quick and fair peer-review system, which is all easy to use. Visit <http://www.dovepress.com/testimonials.php> to read real quotes from published authors.

Submit your manuscript here: <https://www.dovepress.com/neuropsychiatric-disease-and-treatment-journal>

Dovepress
Taylor & Francis Group