NeuroFX
Changing Minds

SLEEP AND NEURODIVERGENCE · 12.7

Delayed Sleep Phase in ADHD Adults

A significant minority of adults with ADHD have delayed sleep phase syndrome as a separate clinical picture on top of the broader ADHD-sleep relationship. The distinction matters because DSPS has its own diagnostic criteria and treatments.

FOR
Adults with ADHD whose natural sleep onset is very late

AUDIENCE AGE
18+

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PART OF
The NeuroFX resource library

info@neurofx.co.uk · 0333 533 3303 · neurofx.co.uk

IN SUMMARY

Delayed Sleep Phase in ADHD Adults

What it is, and what it is not

- **A recognised circadian rhythm disorder.** Delayed sleep phase syndrome is in ICSD-3-TR. Persistent late sleep onset (typically after 1am or 2am, often much later), restorative sleep when allowed to wake later, present for at least three months, with significant distress or impairment from the misalignment.
- **Not the same as being a night owl.** Many people have a slightly later natural rhythm and function fine with effort. DSPS is the clinical extreme: the natural rhythm is shifted so far that conforming to a typical schedule is genuinely difficult and produces ongoing functional cost.
- **Overlaps heavily with adult ADHD.** The dopamine and circadian biology of ADHD predisposes to DSPS. Kooij and Bijlenga document the population-level DLMO shift of 60 to 90 minutes; in a meaningful minority of adults with ADHD, the shift is large enough to meet DSPS criteria.

How it is diagnosed and treated

- **Diagnosis is clinical.** Sleep history, sleep diary across two to four weeks, often actigraphy, sometimes DLMO measurement in a specialist clinic. GP referral to sleep medicine is the UK route.
- **Morning bright light is the highest-yield intervention.** 30 to 45 minutes within an hour of the desired wake time, daily. Dose-dependent and consistency-dependent; missing days resets some of the progress.
- **Evening light reduction compounds the morning light effect.** Reducing bright-light exposure (particularly blue-spectrum from screens) in the two hours before the desired sleep time. Less powerful alone; useful in combination.
- **Timed off-label melatonin is a clinical decision.** Small doses taken several hours before desired sleep time can phase-advance the rhythm. Different from taking melatonin to knock yourself out at bedtime. The timing is critical; not to attempt independently.
- **Where treatment is partial, work with the rhythm.** Flexible start times at work (Equality Act reasonable adjustment where ADHD is recognised as a disability), protected sleep window, consistent wake time, careful stimulant medication timing.

How we can help

- **GP for sleep medicine referral.** Wait times vary substantially. Specialist sleep psychology services exist in some regions and are useful for DSPS specifically.
- **Prescriber for the ADHD medication timing question.** If your medication is taken at 7am and you wake at 10am, the medication has been wearing off through your most cognitively demanding hours. NeuroFX prescribing clinicians can address timing for patients we prescribe for.
- **Workplace adjustments where appropriate.** Flexible start times negotiated as a reasonable adjustment under the Equality Act 2010 where your ADHD is recognised as a disability. See our Cat 8 workplace adjustments piece for the broader framework.

WHEN TO SPEAK TO A PROFESSIONAL

Speak to your GP if you consistently cannot fall asleep before 1am or 2am despite trying earlier, sleep restoratively when allowed to wake later, and the misalignment is significantly affecting your function or wellbeing. Ask specifically about sleep medicine referral; sleep psychology services are also useful where available. NeuroFX prescribing clinicians can address the ADHD medication timing question for patients we prescribe for; the DSPS-specific assessment and treatment route is sleep medicine.

SOURCES

Auger 2015 AASM guideline; Kooij & Bijlenga 2013; Bijlenga 2019; Snitselaar 2017; AASM ICSD-3-TR; Faraone consensus 2021