

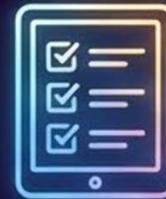
How: AuDHD Diagnostic Framework

1. Clinical History & Childhood Onset



Review of past & current symptoms, incorporating historical records or family accounts.

2. Validated Assessment Instruments



AISRS
(ADHD)



AQ / RAADS-R
(Autism Traits)

Utilizing specific tools for both conditions.

3. Screening for Masking Behaviors



Using tools like CAT-Q
(Camouflaging Autistic
Traits Questionnaire).

4. Functional Impairment Evaluation



Assessing impact in
social, academic, and
occupational areas.

Management:

Most important: Integrated Treatment Strategies for the AuDHD Phenotype

Pharmacological: Sensory-Informed Medication Management



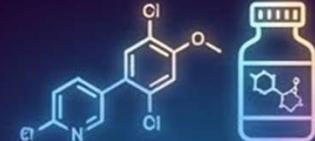
Phase 1

Long acting methylphenidate or lisdexamfetamine low starting (18mg Concerta or 20 mg Vyvanse)



Phase 2

If not tolerate, switch to Atomoxetine



Phase 3

Considering Alpha-2 agonists (Prazosin or Guanfacine ER) or low dose Risperidone



Emerging

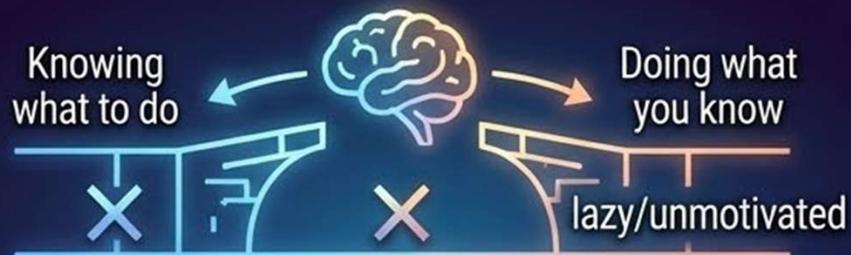
Centanafadine (NDSRI)

“Sensory diet”

Sensory Need	Potential Intervention/Activity	Functional Goal
Hypersensitivity (Noise/Light)	Noise-canceling headphones; dimnable LEDs; blue-light filters.	Reduce sensory overwhelm and cognitive fatigue.[22, 23, 24]
Hyposensitivity (Tactile/Movement)	Weighted blankets; fidget tools; wall push-ups; crunchy snacks.	Increase alertness and body awareness.[22, 25, 26]
Proprioceptive Deficits	Yoga; joint compressions; weighted lap pads.	Improve grounding and reduce anxiety during transitions.[22, 27, 28]
Vestibular Regulation	Gentle rocking; movement breaks; stability ball seating.	Balance the nervous system and improve focus during seated tasks.[22, 29]

Psychotherapeutic Modalities

Adapt CBT (Neuro-affirming Cognitive Behavioral Therapy)



- **Targeting Procrastination:** Breaking down tasks ('micro-steps'), using externalized memory (digital calendars, apps).



- **Cognitive Restructuring:** Reframing ADHD traits as neurological differences, not flaws.



- **Executive Function Integration:** Coaching to apply insights to real-world tasks.

Dialectical Behavior Therapy (DBT) & Emotional Dysregulation



1. **Mindfulness (Wise Mind):** Balancing emotional urges with rational goals. Adapted for neurodiversity with movement, music, 'special interest focus'.



2. **Distress Tolerance (TIPP)** (Temperature, Intense exercise, Paced breathing, Progressive relaxation) to rapidly lower arousal during meltdowns.



3. **Interpersonal Effectiveness** Teaches assertive communication & boundary setting, vital for navigating social cues & people-pleasing.

The RISE and RASP Frameworks

Coaching Frameworks



Coaching Strategies & Tools



“Externalizing”: Using external tools to manage internal functions.



“AirTags”: For frequently lost items.



“Body Doubling” sessions: For motivation and focus.



“Personal Toolkit”: Development of strategies that respect their unique neurotype.

Social communication= significant area of challenge for AuDHD

Module <input type="checkbox"/>	Specific Competency Target	Lived Experience Application
Conversation Skills	Initiating small talk; finding common interests.	"Conversation toolkit" with authentic questions
Electronic Communication	Nuances of texting, email, and social media.	Managing "unspoken rules" of digital social interaction.
Conflict Management	Handling direct/indirect bullying; arguments.	De-escalating disagreements without sensory meltdowns.
Dating and Intimacy	Disclosing neurodivergence; reading romantic cues.	Navigating the complexities of consent and rejection.

Management for Case Study

1. Pharmacological



Risperidone 0.5mg bd



Atomoxetine 25mg
mane * 2 weeks, then
increased to 40mg mane
for 2 weeks



2. Coaching: strategies of managing



sensory diet



TIPP



communication
coaching

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Management for Case Study



1. Initial Phase: Risperidone



- 0.5mg Risperidone bd for 4 weeks



2. Subsequent Phase: Atomoxetine Titration



- Atomoxetine 25mg mane *2 weeks, titrating up to 60mg by week 5.

Taylor and Rodriguez (2025)

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