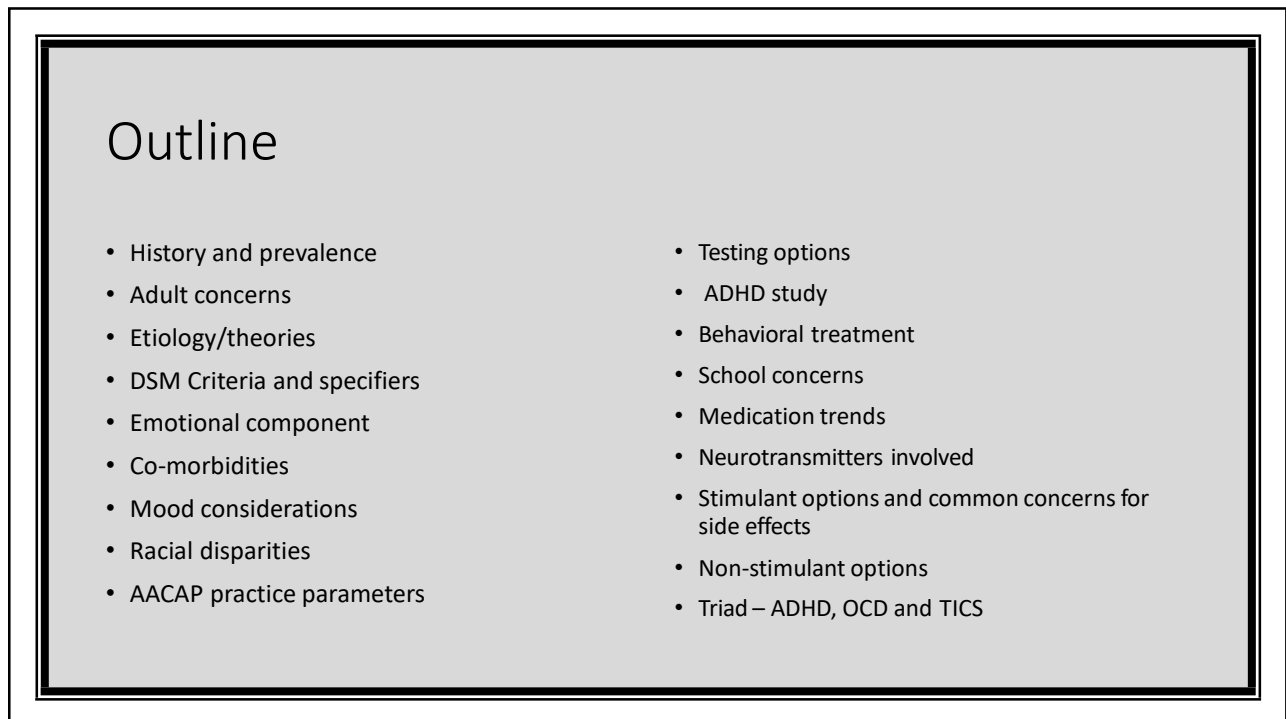
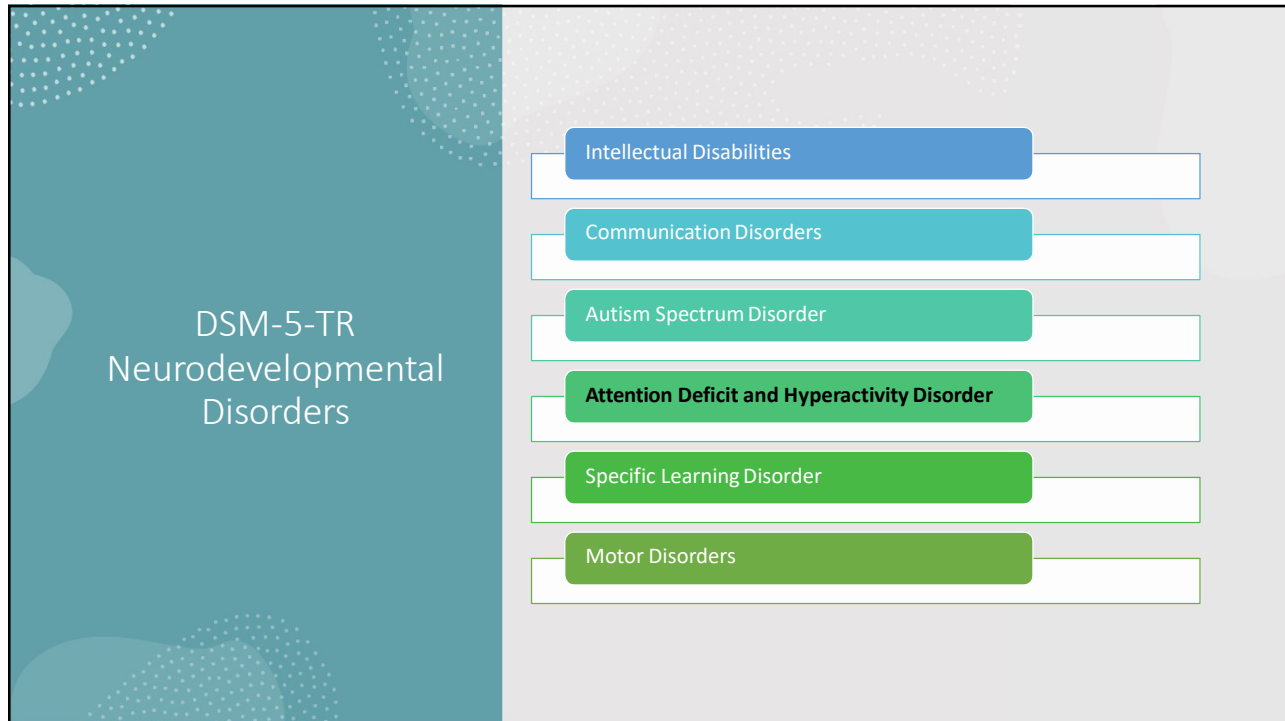


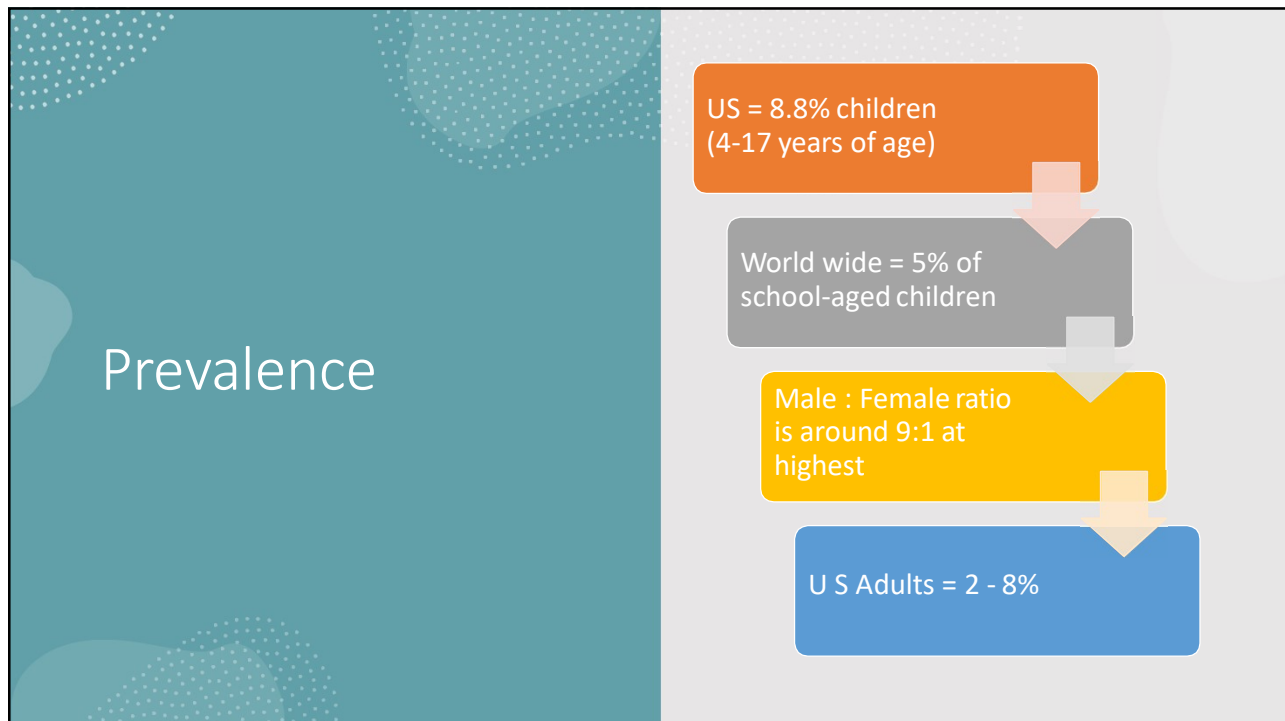
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3



4

DSM-5-TR ADHD criteria

- 6/9 criteria of inattention and hyperactivity/impulsivity symptoms
- Present for at least 6mos
- In at least 2 different settings
- Symptoms present at least before 12yo (whether or not treated)
- Clear interference with social, occupation, or academic function
- Not better explained by another mood/psychotic disorders

5

Potential adult consequences

Relationship difficulties

Injuries and accidents

Academic/employment difficulties

Antisocial and criminal behavior

Health problems

Teen pregnancies

6

Etiology

- "Principal cause is genetic"- heritability approximately 76%
 - Associated with chromosomes 5, 4, 6, 8, 11, 16, & 17
- Perinatal stress, low birth weight, traumatic brain injury, maternal smoking during pregnancy, and severe early deprivation
- August is a peak month for births of children with ADHD....however...
 - Maternal "winter" infection during first trimester of pregnancy?
 - Or related to school age cut off?

7

Inattentive:

Avoids tasks requiring sustained mental effort

Difficulties with organization

Distractible

Careless mistakes - difficulties with working memory

Difficulty listening

Forgetful especially with daily tasks

Difficulty with sustaining attention

Difficulty following through or finishing tasks

Often loses things

8

Hyperactive/ Impulsive

- "On the go" "Driven by a motor"
- Distractible
- Leaves classroom seat
- Fidgets/taps/squirms
- Blurts out answers
- Interruptive
- Runs/climbs not in correct setting; restless
- Difficulty waiting their turn
- Talks excessively

9

Emotional dysregulation

"Emotion dysregulation arises when these adaptive processes are impaired, leading to behavior that defeats the individual's interests."

1. Excessive/out of proportion
2. Poorly Controlled
3. Rapid
4. Not always physical aggression (linked more to hyperactivity than inattention)

25-45% of children with ADHD

30-70% of adults with ADHD

10

Comorbidities

- 54-84% Opposition Defiant Disorder (ODD) and possible Conduct disorder (CD)
- 25-35% Language or learning problems
- 33% Depression
- 19% Substance use
- 16% Bipolar disorder

11

Mood considerations

- Emotionally labile, explosive, lack focus – misinterpreted as oppositional behavior
- Demoralized / poor self esteem- in reaction to persistent frustration with academic/social difficulties
- No longer constantly reprimanded can increase mood and self esteem

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Helpful expectations

- Child may not “voluntarily” exhibit symptoms but is capable of meeting reasonable expectations.
- Typical tasks of maturation help build self-esteem when they develop a sense of mastery. Don't take these chances away.
- They do NOT benefit from being exempted from the requirements and expectations like other children.

13

ADHD Racial Disparities

- Racial disparities exist - research observed kindergarten to 8th grade
 - Minority children were less likely than white children to receive diagnosis of ADHD.
 - English speaking, male gender, older mother, & externalizing behaviors increased chance
 - Academic achievement, some attentiveness, & no insurance decreased chance
 - Other times they are misdiagnosed with ODD instead of ADHD
 - Willful or not?
 - Also issues of lack of access to treatment once diagnosed
- Culturally sensitive assessments are required
 - Families may not report history - worried about “label” and further discrimination
- Serious impact
 - Those with ADHD already risk for incarceration, teen pregnancy, substance use, etc.

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AACAP Practice Parameters

- 1) Screen
- 2) Evaluate
- 3) Rule out – examples: lead exposure, hyperthyroidism, head injuries, in utero drug exposure, etc.
- 4) Look for comorbidities - including substance use
- 5) Offer medication and behavioral treatment
- 6) If no academic improvement in 1-2 weeks – psych test looking for specific learning disorders

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Common Behavior Rating Scales Used in the Assessment of ADHD and Monitoring of Treatment

Name of Scale	Reference
Academic Performance Rating Scale (APRS)	The APRS is a 19-item scale for determining a child's academic productivity and accuracy in grades 1Y6 that has 6 scale points; construct, concurrent, and discriminant validity data as well as norms ($n = 247$) available (Barkley, 1990).
ADHD Rating Scale-IV	The ADHD Rating Scale-IV is an 18-item scale using DSM-IV criteria (DuPaul et al., 1998).
Brown ADD Rating Scales for Children, Adolescents, and Adults	Psychological Corporation, San Antonio, TX (www.drthomasebrown.com/assess_tools/index.html) (Brown, 2001)
Child Behavior Checklist (CBCL)	Parent-completed CBCL and Teacher-completed Teacher Report Form (TRF) www.aseba.org/index.html
Conners Parent Rating ScaleYRevised (CPRS-R) ^a Conners Teacher Rating ScaleYRevised (CTRS-R) ^a Conners Wells Adolescent Self-Report Scale	Parent and adolescent self-report versions available (Conners, 1997) Conners, 1997 Conners and Wells, 1997
Home Situations QuestionnaireYRevised (HSQ-R), School Situations QuestionnaireYRevised (SSQ-R)	The HSQ-R is a 14-item scale designed to assess specific problems with attention and concentration across a variety of home and public situations; it uses a 0–9 scale and has test-retest, internal consistency, construct validity, discriminant validity, concurrent validity, and norms ($n = 581$) available (Barkley, 1990).
Inattention/Overactivity With Aggression (IOWA) Conners Teacher Rating Scale	The IOWA Conners is a 10-item scale developed to separate the inattention and overactivity ratings from oppositional defiance (Loney and Milich, 1982)
Swanson, Nolan, and Pelham (SNAP-IV) and SKAMP Internet site ADHD.NET	The SNAP-IV (Swanson, 1992) is a 26-item scale that contains DSM-IV criteria for ADHD and screens for other DSM diagnoses; the SKAMP (Wigal et al., 1998) is a 10-item scale that measures impairment of functioning at home and at school.
Vanderbilt ADHD Diagnostic Parent and Teacher Scales	Teachers rate 35 symptoms and 8 performance items measuring ADHD symptoms and common comorbid conditions (Wolraich et al., 2003a). The parent version contains all 18 ADHD symptoms, with items assessing comorbid conditions and performance (Wolraich et al., 2003b).

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The Multimodal Treatment Study of Children with ADHD (MTA)

- Over 500 participants ages 7-9yo with ADHD
8 follow-ups (2,3,6,8,10,12,14,&16 yr)

•90% had residual symptoms in adulthood

Also compared treatments:

1. Behavior therapy (Beh)
2. Medication management (Med Mgmt)
3. Combination (Comb) of Beh and Med
4. Self selected community care (Com)

•Results: Comb and Med Mgmt showed greater improvement than the Beh and Com

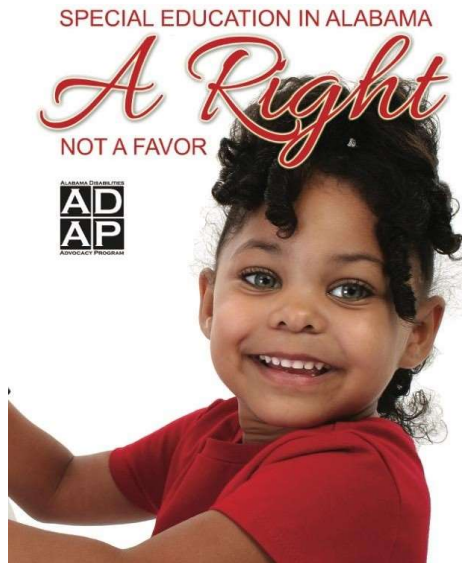
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Behavioral treatment

- **Parents** - Psychoeducation and parent training
 - decrease negative family dynamics and increase emotion regulation in both
- **Child** - Cognitive behavioral therapy (CBT) recognize and label emotions accurately and challenge emotions which are not in context
 - Group therapy aimed at refining social skills and increasing self-esteem
- **Teachers** - academic organization skills and behavior modification
 - Individual Education Program (IEP)

18

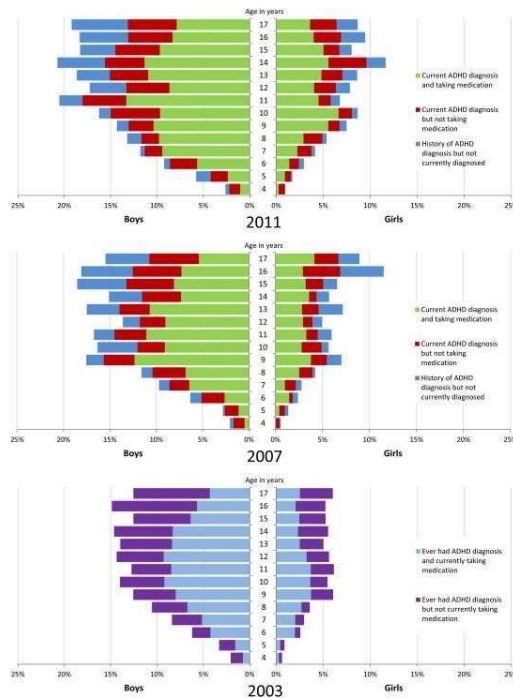
Individual Education Program (IEP)



<https://adap.ua.edu/special-education.html>

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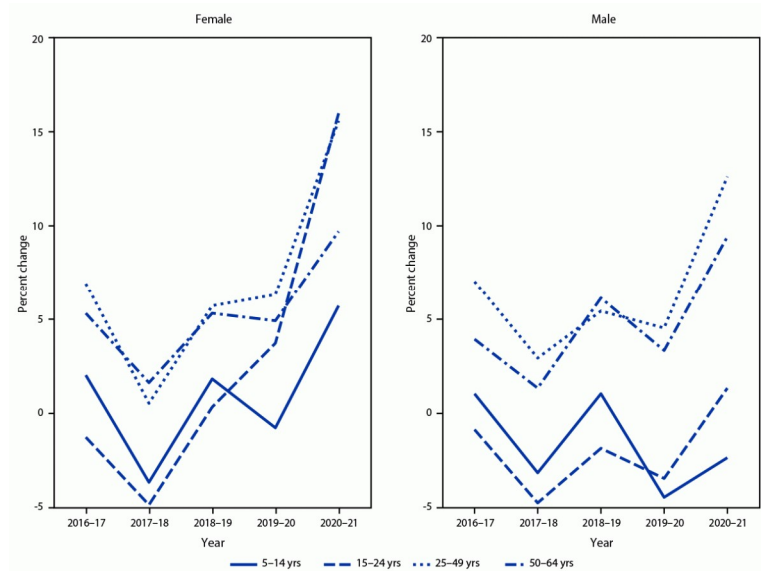
Trends in ADHD medications



20

Telehealth - Boom and Bust

Relative annual percent change in percentage of persons aged 5–64 years with at least one stimulant prescription fill, by sex and age group



21

Key Neurotransmitter Functions

Dopamine

- Movement
- Memory
- Pleasurable reward and motivation
- Behavior and cognition
- Attention
- Sleep and arousal
- Mood
- Learning

Norepinephrine

- Arousal
- Attention
- Vasoconstrictor - maintains blood pressure
- Sleep wake cycle
- Mood
- Memory

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Pharmacotherapy considerations....

- Do NOT improve any impairments in learning, but when attention is focused, children can learn effectively.
- Central nervous system stimulants are the 1st choice - greatest efficacy with mild side effects.
- Timing of behavior problems – ADHD pattern vs. medication.
- Preschooler dosing must be conservative, otherwise increases further deregulation.

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ADHD Medication Guide*

Revised: December 1, 2023

Methylphenidate Formulations – Long Acting, Oral**			
(Capsules and tablets in this section are shown at actual size)			
Concerta®†	6-12 Yrs: 18-54mg, SO, 18mg 13-17 Yrs: 18-72mg, SO, 18mg ≥18 Yrs: 18-72mg, SO, 18mg or 36mg	[C]	27mg
Focalin® XR†	6-12 Yrs: 5-30mg, SO, 5mg 18 Yrs-Adult: 5-60mg, SO, 5mg (bupropion – 30/50)	[C]	5mg
Cotempla XR-ODT† ¹	6-17 Yrs: 6-51.8mg, SO, 17.3mg (strip form)	[C]	8.6mg
Aplenzin® XR†	6 Yrs-Adult: 10-60mg, SO, 10mg (bupropion – 40/10)	[C]	10mg
Quilivant XR®	20mg (mg/mL) (bupropion ER)	[C]	10mg
Quilivant ER® ²	6 Yrs-Adult: 20-60mg, SO, 20mg (bupropion – 30/10)	[C]	20mg
Ritalin® LA†	6-12 Yrs: 10-60mg, SO, 20mg (bupropion – 30/50)	[C]	20mg
Metadate® CD†	6-17 Yrs: 10-60mg, SO, 20mg (bupropion – 30/10)	[C]	20mg
Metadate® ER†	6 Yrs-Adult: 20-60mg, SO, 20mg	[C]	20mg

Methylphenidate Pro-Drug Formulations - Long Acting, Oral**			
(Medications in this section are shown at actual size)			
ADZILEVY®†	6-12 Yrs: 26.1-52.2, 370.4, SO, 39.2/7.8 mg, 13 Yrs-Adult: 39.2/7.8 - 52.2, 370.4, SO, 39.2/7.8 mg	[C]	26.1mg SO / 7.8mg d-MPH

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral**			
(Medications in this section are shown at actual size)			
Jornay PM®†	6 Yrs-Adult: 20-100mg (dosed in the evening), SO, 20mg	[C]	20mg

Methylphenidate Formulations – Short Acting, Oral**			
(Medications in this section are shown at actual size)			
Focalin® (methylphenidate)	6-17 Yrs: Daily: 5-20mg, divided BID, SO, 2.5mg BID	[C]	2.5mg
Ritalin®	6-12 Yrs: Daily: 10-60mg, divided BID or TID, SO, 5mg BID Adult: Daily: 10-60mg, divided BID or TID	[C]	5mg
Methylphen Chewable† Sprinkle Form†	6-12 Yrs: Daily: 10-60mg, divided BID or TID, SO, 5mg BID Adult: Daily: 10-60mg, divided BID or TID	[C]	5mg
Methylphen® Solution (sprinkle form)†	6-12 Yrs: Daily: 10-60mg, divided BID or TID, SO, 5mg BID Adult: Daily: 10-60mg, divided BID or TID	[C]	5mg/5mL

Methylphenidate Formulations – Long Acting, Transdermal

Daytrana®
6-17 Yrs: 10-30mg, SO, 10mg
(Methylphenidate transdermal system) 1.5"x3.9" (3.8cm x 9.9cm)
The size shown around each patch reflects the size of the packaging, not the patch itself.

Daytrana (methylphenidate) transdermal system 1.5"x3.9" (3.8cm x 9.9cm)
20mg / 9 hrs
1.5"x3.9"

Administration Key:

- † Daily disintegrating tablet
- † Can be mixed with yogurt, orange juice, or water
- † Can open capsule and sprinkle medication on apple sauce
- † Can open capsule and sprinkle medication into water or onto apple sauce
- † Can open capsule and mix with apple sauce or yogurt
- † Indicates a generic formulation is also available; generic products are not shown
- † Indicates a generic (but NOT a branded) formulation is available

* View the latest version of the ADHD Medication Guide at: www.ACHDmedicationguide.com

• Updated versions of the ADHD Medication Guide can be viewed at: www.ACHDmedicationguide.com

• Limited copies of the ADHD Medication Guide can be ordered on-line from the ADHD Warehouse

• Contact Dr. Andrew Adelman with any comments or suggestions: ACHDMedicationGuide@Northwell.edu

***Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available through, in some cases, brand or generic equivalents are not available: Adhansia XR, Admora ER (Bupropion), Cylert (pemoline), Dexamine Spansules (5mg, 15mg), Dexamine Tablets, Dexamine Tablets, Daytrana Solution, Metadate CD capsules, Metadate ER tablet (10mg), Methylphen Chewable tablets, Ritalin LA capsule (60mg), Ritalin SR tablets (20mg).

†Important Information: The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SO" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. Please note: medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

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ADHD Medication Guide*										Revised: December 1, 2023
Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)										
Dyanavel ^{XR} (lisd-amphetamine sulfate)	6 Yrs-Adults: 2.5–20mg; SD: 2.5 or 5mg	5mg	10mg	15mg	20mg					
Dyanavel ^{XR} (lisd-amphetamine sulfate) (bubblegum flavor)	6 Yrs-Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis [®] (mixed amphetamine salts)	13–17 Yrs: 12.5–15mg; SD: 12.5mg Adults: 12.5–50mg; SD: 12.5mg	12.5mg	25mg	37.5mg	50mg					
Adzenys ^{XR-ODT} [®] (lisd-amphetamine sulfate) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–15.5mg; SD: 6.3mg Adults: 12.5mg	3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg			
Adderall ^{XR} [®] (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5–30mg; SD: 20mg (biphasic – 50/50)	5mg	10mg	15mg	20mg	25mg	30mg			
Devedrine Spansule [®] (lisd-amphetamine sulfate)	6–17 Yrs: 10–40mg; SD: 5mg 1–3x/day	5mg	10mg	15mg	20mg	25mg	30mg			
Amphetamine Formulations - Long Acting, Transdermal										
Xelstrin [™] (d-amphetamine)	6–17 Yrs: 4.5–18mg; SD: 4.5mg Adults: 9–18mg; SD: 9mg	4.5mg / 9hrs -0.9" x 0.9"	9mg / 9hrs -1.2" x 1.2"	13.5mg / 9hrs -1.5" x 1.5"	18mg / 9hrs -1.7" x 1.7"					
<i>(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)</i>										
Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)										
Vyvanse [®] (capsules) (lisd-amphetamine)	6 Yrs-Adults: 10–70mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg	70mg		
Vyvanse [®] (chewables) (lisd-amphetamine) (strawberry flavor)	6 Yrs-Adults: 10–70mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg	70mg		
Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)										
Evekeo [®] (lisd-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1–2x/day	5mg	10mg							
Evekeo [®] ODT (lisd-amphetamine sulfate)	6–17 Yrs: 5–40mg divided BID; SD: 5mg 1–2x/day	2.5mg	5mg	10mg	15mg	20mg				
Zenzed [®] (lisd-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–18 Yrs: 5–40mg divided BID; SD: 5mg 1–2x/day	2.5mg	5mg	7.5mg	10mg	15mg	20mg	30mg		
Adderall [®] (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1–2x/day	5mg	7.5mg	10mg	12.5mg	15mg	20mg	30mg		
ProCentra [®] (lisd-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5–40mg divided BID; SD: 5mg 1–2x/day	5mg/5mL								

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Common side effect concerns with stimulants

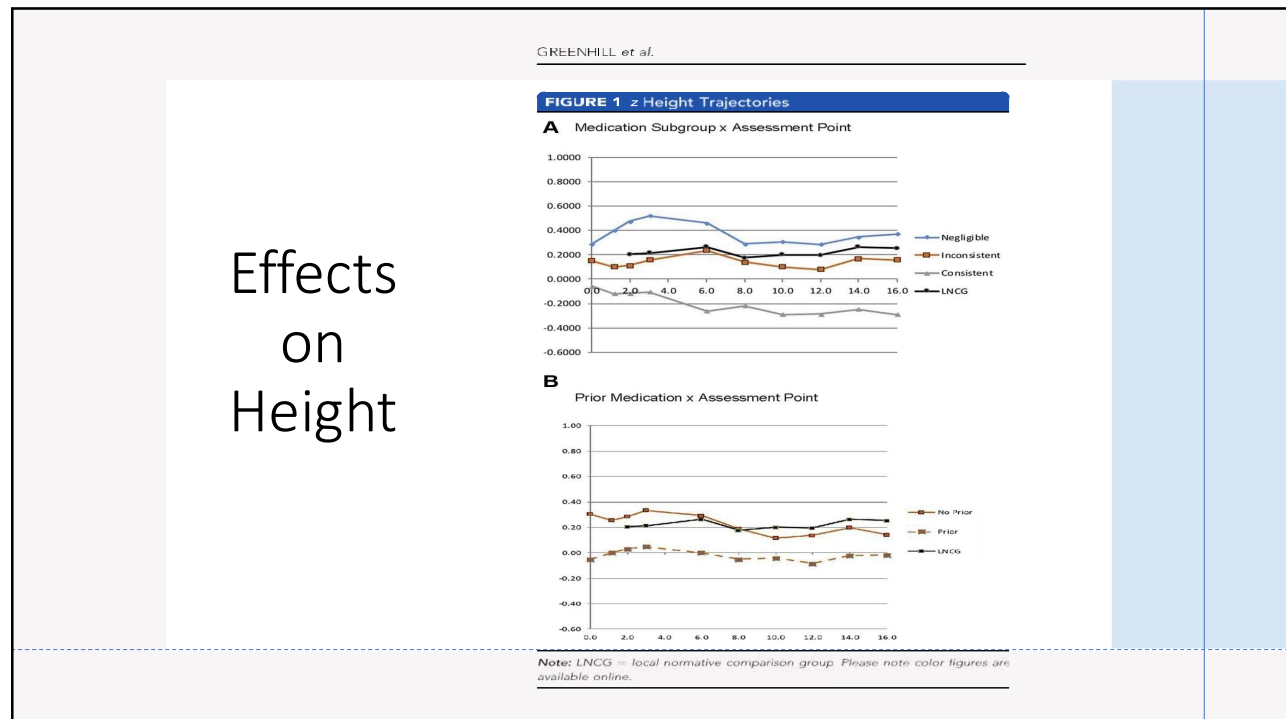
- Growth/weight effects
- Sleep impact
- Cardiac effects
- Tics
- Abuse potential

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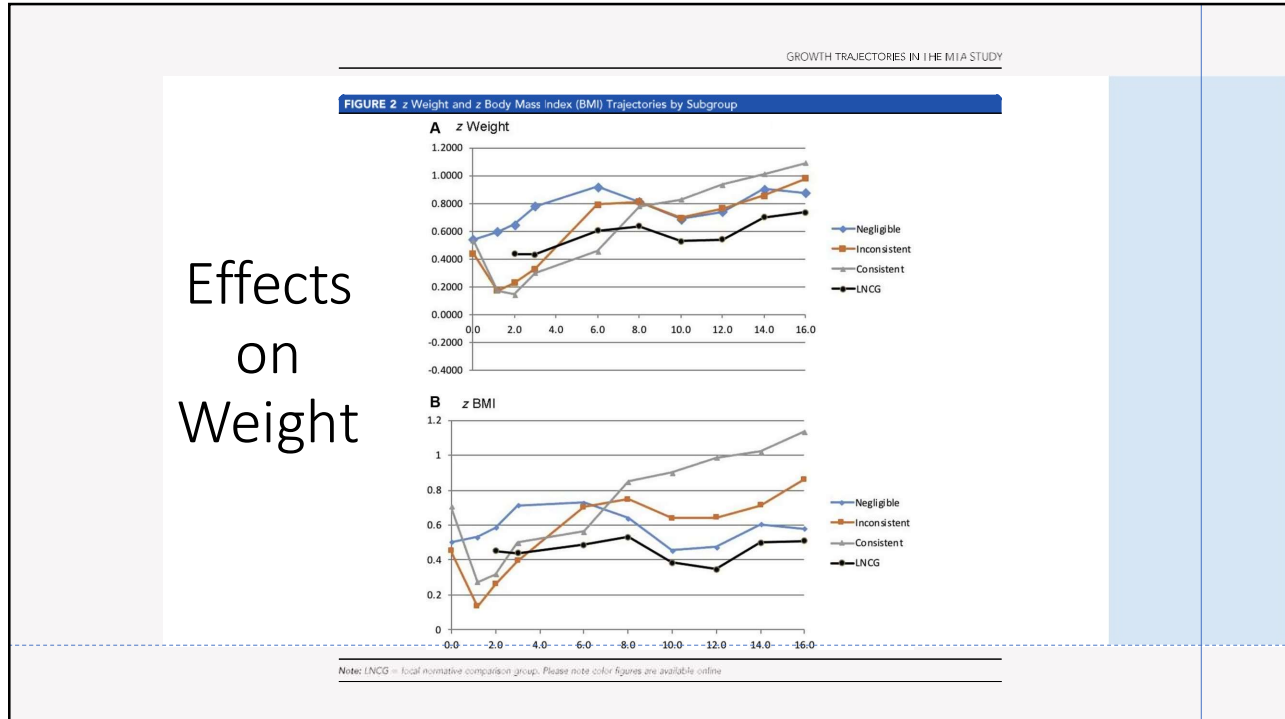
Words of Dr. Stephen Stahl...

“Predict side effects in advance (you will look clever and competent to the parents unless you scare them with too much information and cause nocebo effects, in which case you won’t look so clever when the patient develops lots of side effects and stops medication; use your judgement here) a balanced but honest presentation is an art rather than a science.”

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Sleep considerations

TABLE 4 Healthy Sleep Practices: Recommended Sleep Amounts in Youths

Age	Hours
Newborns (0–2 months)	12–18
Infants (3–11 months)	14–15
Toddlers (1–3 years)	12–14
Preschoolers (3–5 years)	11–13
School-age children (6–10 years)	10–11
Teens (10–17 years)	8.5–9.25

Note: From <http://www.sleepfoundation.org>.³⁸

TABLE 3 Healthy Sleep Practices:

Recommended	Not Recommended
Goes to bed about the same time	Drinks lots of liquids before bedtime
Goes to bed in the same place	Does things that are alerting
Sleeps alone	Uses bed for things other than sleep
Caffeine and naps a maximum of 4 hours before bedtime	Put to bed after falling asleep
Has a calming bedtime routine	Stays up past usual bedtime
Does relaxing things before bedtime	
Gets out of bed at same time in morning	

Note: Selected Items Adapted From the Children's Sleep Hygiene Scale (CSHQ).²⁹

1st line - health sleep practices

2nd - low dose Melatonin (5mg or less)

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As many as 70% of kids ADHD have sleep problems; much more than other individuals.

- “Difficulty falling asleep” is most common
- Comorbidities – consider defiance and anxiety
- Medication use/timing
- Substance use – especially marijuana
- Consider Iron levels - >1/3 women under 50yo are iron deficient
 - Low iron can exacerbate restless leg syndrome
- Pilot RCT showed 5-week elimination diet helped

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Cardiac concerns...not much

- Study involving 1,200,438 children and youth aged 2–24 years using methylphenidate
- Cohort members had 81 serious cardiovascular events (3.1/100,000 person-years).
 - Event = myocardial infarction, stroke, and death
- Current ADHD medication users had no increased risk for serious cardiovascular events
- Stimulants are contraindicated with known cardiac risks – obtain baseline EKG **IF** family history
- Adrenergic effects can cause increases in BP and pulse rate
 - American Academy of Child and Adolescent Psychiatry (AACAP) recommends BP and pulse checked quarterly

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Tic Disorders

Can be motor or vocal

Tourette's = when person has both

Comprehensive Behavioral Intervention for Tics (CBIT) gold standard treatment – based on habit reversal therapy with 86.9% effectiveness at 6-month follow-up

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Concerns for tics....not really

methylphenidate

Studies with methylphenidate worsening occurred in 20% and 22% who received placebo. No significant difference. **First line with tic concerns.**

amphetamine

One small trial of an amphetamine in children with comorbid tics and ADHD; worsening of tics **ONLY** when doses higher than 25 mg/day.

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Drugs with abuse potential may reduce risk of abuse...especially when offered to children!

- TRUE - methylphenidate and amphetamine are sometimes abused
- TRUE – the earlier an individual is exposed to substances with abuse potential, the greater the risk of drug abuse
- ALSO TRUE - **stimulant treatment of children and adolescents with ADHD may reduce the risk of later substance abuse**
- “Because those with ADHD are at higher risk for substance abuse, it is urgent that these two perspectives be addressed properly.”

Volkow and Swanson (2008) American Journal of Psychiatry

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Non-stimulants

Non-Stimulants** (Medications in this section are shown at actual size)										
Intuniv®† (guanfacine, extended release)	6-17 Yrs: 1-4mg; SD: 1mg 18-17 Yrs: 2-8mg; SD: 2mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; max increased to 0.17 mg/kg/day	1mg	2mg	3mg	4mg	6mg				
Kapvay®† (clonidine, extended release)	6-17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	<30kg: 0.5mg/kg x 3days, then 1.2mg/kg 30-70kg: 40mg x 3days, then 80mg >70kg: 40mg x 3days, then 80mg p.o. daily	10mg	18mg	25mg	40mg	60mg	80mg	100mg		
Qelbree®† (viloxazine)	6-11 Yrs: 100-400mg; SD: 100mg 12-17 Yrs: 200-400mg; SD: 200mg Adults: 200-400mg; SD: 200mg	100mg	200mg	300mg	400mg	600mg				

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Alpha agonists

1) clonidine:
Catapres: short-acting
Kapvay: long-acting
Less selective and helpful with insomnia if offered at bedtime

2) guanfacine:
Tenex: short-acting
Intuniv: long-acting

- BOTH....
 - Mono therapy and adjunct agents – approved for Pediatric ADHD
 - Monitor blood pressure and pulse – do not stop abruptly or risk hypertensive crisis
 - Effective for tics per practice AACAP practice parameters (2013)
 - Common side effects – include sedation, fatigue, nausea, and hypotension

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Non-stimulants

1) Norepinephrine reuptake inhibitor:
atomoxetine (**Strattera**):
Pediatric ADHD

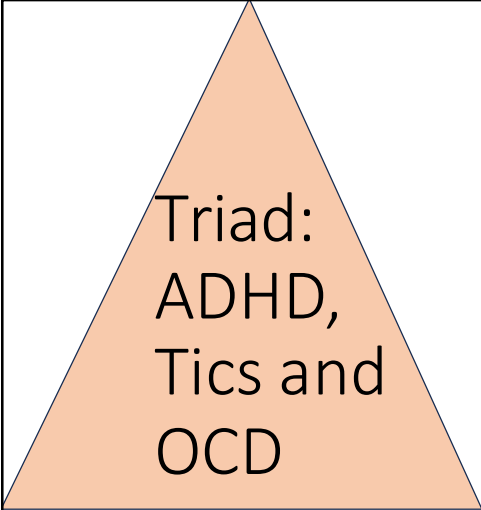
- Offers reduction in anxiety
- Option for those with a substance use problem, comorbid anxiety, or tics.

2) Serotonin norepinephrine reuptake inhibitor (SNRI):
viloxazine (**Qelbree**):
Pediatric ADHD

- Was marketed in Europe as antidepressant initially

Both have black box warnings.
Sedation and GI complaints are most common side effects.

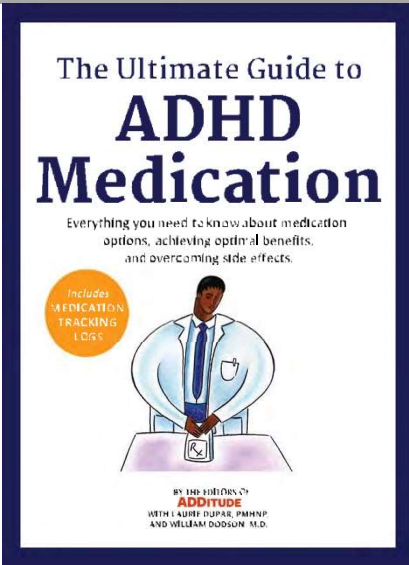
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Triad:
ADHD,
Tics and
OCD

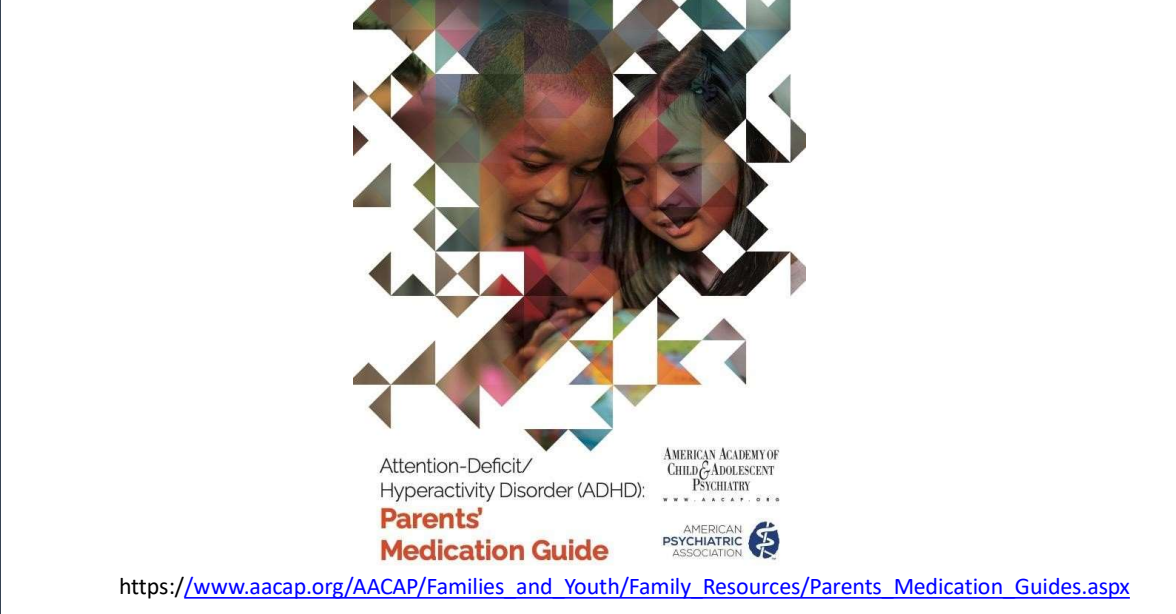
- 2/3 of kids with Tourette’s disorder also have ADHD and OCD
 - Only 15% have uncomplicated Tourette’s
- Failure to inhibit intrusive thoughts “obsessions”
- “Compulsions” and tics may be on a continuum

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<https://www.additudemag.com/download/ultimate-guide-adhd-medications/>

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Attention-Deficit/
Hyperactivity Disorder (ADHD):
**Parents'
Medication Guide**

AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

AMERICAN
PSYCHIATRIC
ASSOCIATION

https://www.aacap.org/AACAP/Families and Youth/Family Resources/Parents_Medication_Guides.aspx

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