

Predictable Solutions

For
The 10 Most Common
Challenges
With ADHD Medications

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Predictable Solutions

If words are not things, or maps are not the actual territory, then, obviously, the only possible link between the objective world and the linguistic world is found in structure, and structure alone.

Alfred Korzybski¹

I wish I had an answer to that, because I'm tired of answering that question.

Yogi Berra

Brief Introduction

In any basic global assessment regarding the diagnosis and treatment for ADHD, practitioners in the USA emerge as the world thought leaders.

Why then, do so many professionals not pay attention to the important medical and scientific details of the medications used for paying attention? Simple answer: ADHD is far more complex than we give it credit for – and it looks just too easy to treat on the front end. Looks can be deceiving.

Let's start with some fundamentals.

On superficial review, it does first appear that stimulant medications are simple to adjust - because when starting from a clinical baseline of obvious ADHD problems, and suddenly experiencing some improvement with medications, one can claim apparent success quite easily, with almost no effort.

This history of unusual success with nearly thoughtless interventions leads many to think that ADHD indeed requires *no thought* – that one can use routine, cookie cutter medication protocols, that one can whimsically titrate stimulant medications, that one can even direct the patients to manage their own titration strategies. “If it's too much, you will feel weird.”

This brief report condenses specific solutions to many of the vexing and complex ADHD medication problems. To meet the promise of predictable solutions in the title I

¹ [Korzybski, A.](#) *Science and Sanity: An Introduction to Non-Aristotelian Systems and General Semantics* 4th Ed 1958.

have also outlined some *specific medication solutions* that I do hope you will find useful, knowing that the reasoning and details will take more time to fully explain. Those details, beyond the scope of this white paper, will be addressed in the book linked at the end of this piece.

Medications are, of course, not the only intervention for ADHD challenges, but other treatment options are beyond the scope of this brief report.

First identify the specific problems, and then consider the predictable solutions. Remember, words – labels - are not things, and the maps are not the territory. Our targets are changing.

Problem #1: Overlooking Targets - Beyond Diagnostic Labels

Let's start with the basics. ADHD diagnostic labels currently focus almost entirely on the *surface*, the *description* of ADHD. Hyperactive, Inattentive and Combined are topical, *surface descriptions* from an ancient time when we had no scientifically validated measuring tools to look at the activity of each brain.

From fMRI, to PET, to SPECT, to rEEG, qEEG, to specific neurotransmitter testing we can see *function*, cellular and molecular physiology *actively at work* in the brain.² Functional testing of actual brain activity increasingly brings additional inarguable evidence to the *functional diagnostic process* beyond superficial labels.

Please take a moment to understand this point: I am not suggesting that we rush out and throw away *descriptive* diagnostic tools and insights – to categorically replace them with *only functional* measures. (So often new science comes down to an either/or disagreement, when the real solution is more yes/and.³) Nor am I suggesting that everyone needs a brain scan for informed diagnosis. I am emphatically saying that brain imaging dramatically changes our medication treatment protocols. A brief review of *functional* presentations:

² [Neuroscience References](#)

³ [Kuhn, T](#) *The Structure Of Scientific Revolutions*, 1996

I. Acting ADHD: Acting Without Thinking

Many people think that Hyperactivity, that superficial, descriptive subset, is the *only* ADHD diagnosis,⁴ while in actuality it covers less than 20% of the entire diagnostic field. Acting ADHD includes many levels of acting without thinking, from acting impulsively, to those with hyperactivity. Action with diminished cognition is a functional impairment that often results in acute problems.

II. Thinking ADHD: Thinking Without Acting

With SPECT brain imaging we can see Thinking ADHD⁵ associated with cingulate hyperperfusion, or may be only associated with PFC dysfunction. Cognition without action will cost over time. This excessive thinking, *mentally hyperactive* subset, frequently becomes overwhelmed with unmanageable cognitive abundance, and arrives at a frozen state of 'mental constipation.' They become overwhelmed by cognitive anxiety and the unbearable consequences of the vacillation process. The hallmark features: worrying all the time, indecision, and cognitive dependence in relationships – stuck thinking.

III. Avoidant ADHD: Not Thinking and Not Acting

Avoidant ADHD⁶ looks like Clint in *Gran Torino*, or any hobo drifter. They “don’t need a shrink, don’t need counseling, don’t need medication, and really don’t need anyone,” thank you. This presentation of *refusal to think* appears as a reflex defensiveness against being overwhelmed by personal relationships, conversation, groups, or projects (changing reality) or insight therapy. They can present on the surface as phobic individuals, with social anxiety - but, when closely reviewed, demonstrate a cognitive abundance they regularly seek to avoid. The avoidance often appears as ADHD symptoms in early academic work.

Medication Solutions:

1. ADHD is best treated with stimulant medications, not SSRIs, certainly not tricyclic antidepressants such as desipramine.
2. SSRIs will aggravate ADHD, and increase impulsivity.⁷
3. Phobias and cognitive anxiety, if secondary to ADHD, will respond poorly to the national standard: SSRIs

⁴ [Functional Diagnosis Video](#)

⁵ [Cognitive Anxiety Video](#)

⁶ [Avoidant ADHD Video](#)

⁷ [SSRIs and ADHD](#)

4. Context for ADHD is important; ADHD is most frequently *not* a 24x7 diagnosis. Doing well with video games does not rule out ADHD.
5. Many 'personality/character' presentations may suffer with ADHD.

Problem #2: Neglecting the Evidence of Metabolic Rate:

Don't worry; this metabolic rate thing will be easy. Think burn rate: fast or slow burn. Fast burn rates require much more medication to correct the symptom picture, and slow burn rates require much less medication. Slow burn rates can create unpredictable toxicity with average doses. Think about it. Fast burn is like pine wood on a fire, slow burns like an oak Yule log.

Age, weight, body size, gender, do not consistently effect the burn rate. Autism, brain injury,⁸ Asperger's, and other metabolic variables become far more indicative of sensitivity to medications than those previous markers – often creating a very slow burn rate. Remember, the slow burn rate will show toxicity at even low doses.

The Therapeutic Window

One of the easiest ways to evaluate burn rate is through considering objective assessment of The Therapeutic Window.⁹ Effective medication management works best with a workable window, with sides, a top, and a bottom. I have outlined The Window on one page at the end of this review for easy reference and further distribution. The Therapeutic Window will keep the medical team on target as they assess treatment objectives and medication predictability.

Genetic Variations Can Create Medication Unpredictability

Not commonly appreciated by many is the somewhat obscure fact that Ritalin like products (MPH – methylphenidate) and Adderall like products (AMP – amphetamine) are metabolized through different pathways, different pipelines, in the body. The pipeline for AMP is CYP 450 2D6 (short form: 2D6)¹⁰ and varies genetically, so a few, about 5% Caucasians, will have difficulty with AMP metabolism.

⁸ [Brain Injury and ADHD](#)

⁹ Addendum, page 20, here

¹⁰ [Cozza, et al.](#) *Drug Interactions In Clinical Practice* 2nd Ed

Metabolic rate will determine the Duration of Effectiveness (DOE)¹¹ with these shorter (less than 24 hr) half-life medications. The history of stimulant medications has for years focused on lengthening the half-life with longer acting, time-release agents. Half-life is the expected DOE – burn rate will modify it based on the individual's metabolism.

Medication Solutions:

1. Go low and slow starting every stimulant medication. Titration is the most commonly overlooked challenge with stimulant medications.
2. Review The Therapeutic Window on the Addendum (last page here).
3. Watch carefully at the outset for the DOE to maximize the dose and effectiveness.

Expectations for DOE at the correct dosage:

- a. Ritalin immediate release [IR] – 4hr
 - b. Ritalin extended release [XR] – 8 hr
 - c. Concerta [XR] – 8 -9 hr
 - d. Adderall IR – 5-6 hr
 - e. Adderall XR – 10 hr
 - f. Dexedrine IR – 5 hr
 - g. Dexedrine XR – 7 hr
 - h. Metadate CR [is an XR] – 8 hr
 - i. Focalin IR – 4hr
 - j. Focalin XR – 8 - 9 hr
 - k. Daytrana [MPH] Patch - 10-12 hr
 - l. Vyvanse [AMP] - 12-14 hr¹²
4. Insufficient dosage = less effective/shorter DOE across all medications.
 5. The most effective medications last all day, covering the late PM.
 6. Compliance in the late afternoon drops when adding another IR dose, leaving the evening disorganized and troubled.

Problem #3: Multiple Diagnoses, Emotional Baggage, and ADHD

Multiple diagnoses associated with ADHD are far more common than simple, unadorned ADHD. Miss this point and you miss *most* of the action. The key medical word describing multiple diagnoses for ADHD matters is 'comorbidity.' The importance of multiple diagnoses are several: using the right medications for the

¹¹ [DOE Explained and Video](#)

¹² [Vyvanse Titration](#)

specific diagnosis, correctly organizing several medications with multiple diagnoses, and understanding the likelihood of medication side effects.

When ADHD presents with comorbid bipolar and depression, medications require a specific protocol: 1. First the mood stabilization. 2. Then the antidepressant - and 3. Then the ADHD stimulant medication

Most frequently seen in the office: Depression and anxiety treatable with SSRIs, associated with comorbid ADHD. Complex situations such as these may suffer from multiple neurotransmitter challenges. I use and recommend [neurotransmitter biomarker testing](#) in almost all complex presentations. Evidence is more predictable.

Medication Solutions:

1. Treat comorbid conditions in the correct order.
2. Multiple diagnoses require carefully adjusted multiple medications.
3. Complex presentations require more metabolic review and a better look at neurotransmitter precursors [paid by most insurances].
4. Watch carefully for side effects that might reveal any of these comorbid conditions below.
5. Untreated depression combined with ADHD stimulant meds can look remarkably bipolar.
6. Each psychiatric medication requires its own titration strategy, - has its own characteristic metabolic signature.

Problem #4: Overlooking Depression with ADHD

Depression requires special focus. If depression is overlooked with ADHD, the stimulant medications can significantly *aggravate suicidal thinking and intent*. Do I have your attention?

Look for this important pharmacologic dynamic: Think of a seesaw.¹³ On one end sits serotonin, the neurotransmitter that mainly effects depression and anxiety, on the other is dopamine, the primary neurotransmitter for ADHD. If the patient suffers from both conditions, the seesaw is lowered on both sides forming the shape of the roof of a house. Serotonin is down on the left; dopamine with ADHD is down on the right.

¹³ [SSRIs and ADHD](#)

Correct either one individually, bring that one up to a level horizon, and the consequence for the other, because they are connected on the seesaw, is to bring the opposite side further down. Treat only the ADHD with coexisting depression, and the depression worsens; treat depression without recognizing the ADHD, and the PFC loses control. Memorize this one. Tell your friends.

Medication Solutions:

1. Always check for different signs of depression, both cognitive and affective.
2. Cognitive depression shows as apathy, indifference, attitude, and silence - disconnected. "Guy depression" looks like negative frustration, is often still depression, and beyond gender.
3. Watch for both sides of the seesaw in any clinical evaluation and any clinical history. In adults: a long history of poor response to antidepressants with cognitive confusion after a few days [ADHD], and with children: the hard crash in the PM when the stimulant dose wears off [depression]. If you look, you will see it.
4. Don't mix Paxil or Prozac with either AMP or MPH as they both interact significantly with both medication families, most especially with AMP by plugging the 2D6 pipeline. With mismanaged care and an uninformed emphasis on primitive generic antidepressants, drug interactions abound. Dangerous interactions will most likely become an unpleasant surprise months down the line, if not watched carefully, - another medication challenge with potentially catastrophic consequences.¹⁴

Problem #5: Overlooking Bipolar with ADHD

The current wastebasket diagnosis for many with these brain function, diagnostic, and pharmacologic issues is bipolar disorder [BPD]. If the mood swings, it's bipolar. And in some cases, it is.

Consider these bipolar proactive solutions:

Medication Solutions:

1. Bipolar moods do not exclude, as some indicate, the possibility of using antidepressants or stimulants.¹⁵

¹⁴ CorePsych Books: [Drug Interaction Books](#)

¹⁵ [Bipolar and ADHD Review](#)

2. Use the treatment priorities outlined in Problem #2 above when considering treatment of comorbid BPD and ADHD.
3. Titrate stimulant drugs far more carefully, adjusting dosage over longer periods. No rapid stimulant additions. We cannot prevent all mood swings, but stabilization with stimulants, if indicated, can significantly contribute to emotional stabilization.
4. Look carefully in the childhood history for signs of ongoing unmanageable cognitive abundance. ADHD moods often show a contrite self-reflection – bipolar less so.
5. If mood disordered, always review carefully for substance abuse. Warn carefully about substance abuse; street drugs with the combination of ADHD and bipolar can create havoc. At first you feel smart and bulletproof, then you become stupid, and dangerous to yourself.
6. If moods are present, attempt to differentiate and investigate head injury, brain trauma with functional imaging such as SPECT. Often MRI and CT scans don't show serious *functional brain* impairment.

Problem #6: Overlooking Brain Injury with ADHD

At first blush, ADHD diagnosis seems quite simple; just make the focus and attention diagnosis with various testing tools, watch for comorbid diagnostic issues, and start ADHD medications. But traumatic brain injury [TBI] can completely unwind the treatment process. If you miss TBI, stimulant medications can create massive difficulties from psychosis, to physical destructiveness, to aggravation of substance abuse problems.

Oftentimes individuals who suffer with injury simply don't recall the event, and often only with SPECT scans in hand do they remember the entire injury – so careful questioning is in order. One very interesting person in my office simply could not remember injury, until I repeatedly questioned him about various possibilities. After a pregnant pause in the interview he asked, "Does getting struck by lightning count?" They thought he was dead for 10 minutes. And remember, you don't have to be knocked out to suffer a brain injury – whiplash alone can create an injury process.

Medication Solutions:

1. With TBI, brain injury, treatment is not a one trick pony. Always provide more interventions than just stimulant medications. Stimulants will help somewhat, but the underlying reality, as it is with all of these brain dysregulations, is

restoring the brain, helping it re-grow, and form new neural pathways. We want to support the neuroplasticity,¹⁶ the neurophysiology, the neurotransmitters, the nutrition – everything.

2. Use low dose stimulants here carefully, focusing on the Therapeutic Window, and the specific targets of cognitive dysfunction, not primarily for the depression or moods. Use the Window as a guide regarding DOE, but start medications, if indicated, at less than ½ of a small child’s dose with TBI.
3. Consider neurofeedback,¹⁷ the positive results in the literature, with my colleagues, and in our office have been significant.
4. HBOT, Hyperbaric Oxygen Therapy,¹⁸ has proven extremely helpful to press healing oxygen into the brain cells.
5. In these complex presentations, no single intervention can cover the entire complexity for neuronal recovery.

Problem #7: Overlooking the Therapeutic Window

Dosing strategies require specific oversight. The Therapeutic Window can effectively keep all eyes on this productive process with medication adjustments. Correct functional diagnosis sets the target; the Therapeutic Window sets how you get there.

Finding the Window sounds complicated at first, but in the end, it's easy, and the benefits are clearly measurable. If medications are correctly adjusted, the patient lives right inside that Therapeutic Window: They don't go out the top, nor do they bump on the bottom - they float in the air, right inside that important window. Simply stated: The Window Top correlates with too much, the Bottom with too little, and the sides, the DOE, help add an additional perspective.

The simple objective: think inside the box, and you will be thinking outside the box.

¹⁶ [Doidge N.](#) *The Brain That Changes Itself*, 2007. Specific case reports on Neuroplasticity

¹⁷ [Neurofeedback link: EEG Info](#)

¹⁸ [HBOT at Wikipedia](#)

The Therapeutic Window¹⁹

Represents the body's ability to metabolize the medication effectively. If you simply *pay attention to these simple details* the possibility of the most common two problems with dosing ADHD medications are almost naturally corrected.

1. **The Problem with Stimulant Meds:** The fundamental difference with stimulant medications: they don't last all day - thus the problem with timing. Every medication, each body is built different metabolically, each with a different size pipeline, using different pipelines, and different kinds of speeds - thus the problems with dosage. Cookie cutter dosing strategies create significant problems.
2. **The Custom Job - Beyond Genetics:** The Therapeutic Window is specific for each individual adult or child, not based on your mother, father, sister, brother, or great aunt's experience with medications in general or stimulants specifically. Yes, some families manifest medication sensitivities that may appear genetically related, but don't necessary exclude a low-dose, careful trial.
3. **The Top²⁰ is Toxic:** The dosage is too high, and side effects occur, such as feeling overfocused, agitated, or stoned. If your sleep is significantly disturbed, or your appetite is gone, either the *dose* of the medications or the *medication itself* may be incorrect. Always identify dosage carefully from the moment you begin. Start low, go slow, and don't increase more than weekly or every other week. See the Breakfast section for more help.
4. **The Bottom²¹ Doesn't Work:** Start low at the outset, and dose upward to find the specific range/accuracy markers. Vyvanse often needs little titration - it remains quite stable in dosage over time, and characteristically provides a more cognitive, less anxious clarity to executive function. AMP products require a bit more attention to keep within the Window, but show better efficacy. MPH products appear more forgiving, but still need specific adjustments. Vyvanse, due to its unique prodrug metabolic pattern, is both more predictably effective and more forgiving, although it isn't for everyone.
5. **Sides Show the Duration of Effectiveness²² - DOE:** Measure the hours *exactly*: one side - when did you take it, and the other side - when did it quit working?

¹⁹ [CorePsych Radio: Therapeutic Window](#)

²⁰ [Article: Top of The Window](#)

²¹ [Article: Bottom of The Window](#)

²² [Article: The Sides of The Window](#)

Each stimulant medication lasts only a specific duration. If you are below that expected duration, you are underdosed. If you go past that expected DOE, you are on too much.

6. **Drug Interactions:**²³ Non-stimulant drugs can clog the system, and cause unpredictable problems if they are ignored. This caution involves drugs that interact with the stimulants, especially some antidepressants.
7. **Denial of The Therapeutic Window:** If you don't consider it, if you don't know it's there, you simply cannot target it. If you don't target the Window specifics, you are either shooting geese at night, or simply throwing cans of paint at the barn door, then declaring it painted. Without clear visualization of the target, without paying attention to the details and the edges, initial positive results become predictably negative over time. Stability over time is predictable with consistent parameters.

Medication Solutions:

1. Start medication by looking for duration of effectiveness [DOE] and side effects.
2. Know/teach the DOE for every medication you use, noted above.
3. Begin at the outset to have every member, especially children and adolescents, who often are not consulted, provide input regarding the Therapeutic Window. Feedback with The Therapeutic Window encourages self-mastery, self-esteem, and precise solutions.
4. Use The Therapeutic Window as a guidepost, not an absolute path.
5. Top of the Window problems occur with a too rapid increase in medication, - not providing enough time for the individual to accommodate to the new dosage. Some say 4-6 days – my own view, if possible: 1 week to 10 days.

Problem #8: Overlooking The Protein Breakfast

“Who cares about breakfast? It’s a great thought, but who has the time?” And if you want to look good, it’s an easy diet thing, an irresistible meal to skip. “Hey, I’m doing OK without it, why bother? Pop-Tarts and cereal will do it, no problem – I’m always in a rush in the morning.”

²³ [ADHD Meds and 2D6](#) at Wellsphere

The best brain reason for eating a protein breakfast is simple: neurotransmitter precursors.²⁴ Yes, neurotransmitters do carry the messages, but if you *don't have neurotransmitters*, you can't manipulate them to work better. So how do you grow your neurotransmitter resources? [Protein breakfast fuels the fire.](#)

Medication Solutions:

1. Start at the beginning of stimulant medication treatment with a focus on breakfast proteins, especially with “picky eaters.”
2. Bring the child into the discussion of food choices and work hard to create alternative palate options that include forms of protein.
3. Medication improvements have been reported with protein doses as low as 8 Gm, such as those found in protein breakfast drinks. My own recommendation is to use higher doses of protein, cleaner doses with fewer sugars, such as found in breakfasts with eggs, protein powder on cereals, and protein bars [many have 20 Gm of protein]. Smaller children obviously require less.
4. Any breakfast at all is often helpful, but protein specifically addresses the neurotransmitter challenges so often witnessed with the challenges of morning disarray and ADHD.
5. The incidence of appetite suppression is significantly dropped if medications are given following a protein breakfast, regardless of the stimulant medication in question.
6. Frequently protein breakfasts will encourage more compliance with lunch, and certainly with less rebound, emotional drop, in the PM.
7. School breakfasts present an additional complex problem as often the medications given at home [before breakfast] can create gastric irritation and diminish appetite. Review the alternatives.
8. Best strategy for breakfast at school: some protein [a shake or protein drink?] given at home, before the medication, *then* the school breakfast, with emphasis to the child for protein at school as well. For younger children some give the medications with the nurse at school, following the school breakfast. Find the best solution for your child.
9. Medication checks over time should always include breakfast inquiry, as the medical team can encourage breakfast compliance while the parents often find little support for their recommendations elsewhere. Tell your doctor you need their help with this one.
10. Failure with stimulants: consider neurotransmitter testing, other nutritional testing/intervention, and immune testing. Biologic variables with many somatic

²⁴ [Myths and Misconceptions About Neurotransmitter Testing pdf](#)

conditions can affect stimulant medication outcomes. Protein breakfast solutions work for many, but focus with other biologic variables remains essential.

Problem #9: Overlooking Sleep

Sleep may appear to be the easiest of problems to correct, but it is often the hardest. The sleep experts say we need 8.25 total average hours to defrag the fragmented brain – but, as I often say to the irritated adolescents, I won't hold you to that .25!

If you open Systems Utilities on your PC, you know it takes quite awhile to defrag your desktop, and so it is with your brain. Interestingly, and quite unexpectedly, correcting the ADHD problem with stimulants will often completely correct sleep challenges. Sleep patterns to measure from the outset of medical intervention are:

Total Average Hours - TAH

Begin sleep assessment by doing the TAH math. You know the target is 8.25 hrs, and less than that will bring problems. Do you have trouble is falling asleep, staying asleep, or awakening too early in the morning?

Practice Sleep Hygiene²⁵

In a short summary like this, we cannot cover all the nuances of sleep hygiene. Suffice it to say that:

- a. Sleep time should be consistent
- b. No eating or watching TV from the bed
- c. No caffeinated beverages in the PM
- d. Exercise earlier in the day
- e. Watch that stimulant medications don't create sleep problems

Identify and Treat Comorbid Conditions That Effect Sleep

Depression, mood disorder, bipolar illness, immune dysfunction, stress, brain injury, estrogen dominance [e.g. polycystic ovaries], are just a few of the many comorbid conditions which require their own targeted treatment.

²⁵ [Def: Sleep Hygiene](#)

Medication Solutions:

1. Consider specific pharmaceutical sleep medications for a *prompt response*.
2. Melatonin is an easy, over-the-counter starting point.
3. The inhibitory neurotransmitters L-Taurine 500-1000 mg, and L-Theanine 100-200 mg are also over-the-counter and may prove helpful with out prescriptions.
4. Clonidine at low doses is sedative, not addictive, and often can be used as needed at the 0.1 mg dose for sleep.
5. Consider sleep apnea evaluation if indicated, even in children, as sleep apnea will significantly contribute to poor medication responses treating ADHD.

Problem #10: Overlooking The Significance of Medical Teamwork

Don't just sit on the bench [and privately complain] with your medical team during the stimulant medication game. Medical *team play* is essential to recovery. First, understand the easy, basic medication details, then, discover how to use simple medication rules to help manage your care for the long term. When you understand the simple guidelines in this review, you become a valuable team member.

Do take a personal moment at the outset to discuss with your medical team this medication management process. It will help set the stage for further improved communication. Having spoken to many hundreds of docs over many years about these issues, I can assure you that most will appreciate your insight and perceptions.

What To Say To Set The Stage

Some basic points for your ADHD medical team that may need more attention:

1. Plan to address progress regarding specific functional objectives such as thinking, avoidance, and impulsivity as outlined in the first section.
2. Ask for medical support with nutrition/protein breakfast with ADHD children.
3. Discuss the importance of sleep, and ask for medical help with less than 7 hr of sleep.
4. With children, bring your kids into the dialogue, to affirm/process questions asked to you about them.
5. Their reactions to basic medication management issues will help you understand their perspectives regarding the process of adjusting stimulant medications for ADHD.

6. Feedback connections build self-esteem with anyone taking stimulant medications.

Medication Solutions:

Just a few more overview tips for medication management:

1. As soon as it seems reasonable, help your kids control their own medications responsibly with a 'pill buddy' – the plastic Sun-Sat pill reminders in all the drug stores. Be patient with occasional oversights, they will pay the price for forgetting, and learn responsibility.
2. All the studies recommend that medication treatment over weekends and the summer does provide outcomes that are more predictable. If appetite is an issue, work to correct it through dosage or protein breakfast.
3. Take the time to research more information regarding brain function and ADHD. Do sign up for updates on all of the diversity of diagnostic and treatment matters at [CorePsych Blog](#).
4. Also, stay tuned at CorePsych Blog for more info on *other new ADHD medications* coming out soon that are not controlled substances.
5. If you are simply don't want to use medications at all, do review the CorePsych Blog posts, the page on [Neurotransmitter Testing](#) and other useful references regarding immune testing, and various hormone reviews.

Stay Tuned

The connections in this review are in the hyperlinks. Your patients, friends, and colleagues can download their own hyperlinked and referenced pdf copy with all of the other connections at <http://www.corepsychblog.com/adhdbook>

Do copy this link for them, and this review will be available there to download. Feel free to send this brief paper/pdf to your list, and feel free to distribute it at your website as well.

Thanks for taking the time to join me in this brief review of the evolving science for treatment of ADHD presentations with stimulant medications. I do hope these remarks will help you, your family, and your clients more successfully address some of the challenges seen with ADHD medications.

I will look forward to our next conversations.

For more details on these medications matters:

1. Sign up on this link for updates on publication and availability of [*The Patient's Guide for ADHD Medications – What To Do When Nothing Is Working.*](#)
2. Also, sign up at [CorePsych Blog](#) for regular email missives when I post blog notes on the evolving science – translated into street language for everyday use.
3. Watch for blog/email postings on my new DVD called **BRAIN SCHOOL 101** – a video summary of the evolution of SPECT imaging for accurate diagnosis with a variety of challenging psychiatric presentations.
4. Life is too short - for fun and hanging out with interesting updated ADHD and brain info, sign up for Twitter, and join me and my neuroscience friends at: <http://www.twitter.com/drcharlesparker>
5. See more YouTube Videos at:
<http://www.youtube.com/user/drcharlesparker>

Special Thanks

Thanks to [Gina Pera](#), journalist, and ADHD author [see below], for her analysis and insightful recommendations with this brief review. She's an experienced and fresh voice with years of experience on matters ADHD. Remaining errors or omissions are my own.

Other ADHD Books Strongly Recommended:

Adult ADHD

Gina Pera: [Is It You, Me, or Adult ADD?](#)

Jennifer Koretsky: [Odd One Out: The Mavericks Guide to Adult ADD](#)

Russell Barkley: [ADHD in Adults: What the Science Says](#)

Child ADHD

Russell Barkley: [Defiant Children](#)

Brain Imaging and Diagnosis

Daniel Amen: [Healing ADD](#)

John Ratey: [User's Guide to the Brain](#)

Important ADHD Conferences

[Virtual ADHD Conference](#) Oct. 5-7, 2009

[The Impulsive Brain](#) Oct. 16, 2009

The Therapeutic Window

Dr. Charles Parker - [CorePsych Blog](#)

One Page Overview

Psychiatric medications are just like any other medications: they must always be *adjusted correctly* to *work correctly*. The patient's size and weight no longer matter. Today, medication adjustments are all about this little known mind biomarker: the **Therapeutic Window** – that highly individualized place the medications work in proper adjustment for that specific person.

Sides of the Window - 7 Tips on Duration: Too Long or Too Short

1. **The Sides Are Based Upon Time: The Expected DOE** - Duration of Effectiveness of that must be customized for every person from the outset during treatment.
2. **Know Medication DOE Expectations** from the Outset: See [this review](#) for DOE details.
3. **Measure Precisely the Time DOE At Every Meeting:** Easy questions: "When did you take it and when does it stop working?" If taken at 7 AM, and it lasts until 3 PM - that is the DOE – 8 hr.
4. **The First Side Objective - AM Onset:** All meds should be working in 30-45 min *after taking the medication*. If the AM Onset is more than 45 min, the dose is *either too little*, it isn't working at all, or *could be a sign of toxicity*: See Cyclic Top below.
5. **Regulating the AM Onset:** Breakfast is essential, protein breakfast works best
6. **Second Side Objective - The PM Release** - When They Stop Working: Finding the PM release will help dial in the correct dose for DOE expectations.
7. **The Mystery Objective: The PM Release with Vyvanse:** Vyvanse deserves it's own tip because it is so effective, with such an excellent, predictable 12-14 hr DOE. Remember with Vyvanse: look for the original cognitive, "mental" objectives, not the somatic, buzzy effects. When Vyvanse quits in the PM the ability to finish tasks is gone.

Top of the Window - 7 Tips on Toxicity: Too Much

1. **The Reasonable Objective** - No side effects: If the medication is *just right* in dosage and duration, you will feel no problem, and no, or very few, "side effects."
2. **Drugged** is simply feeling: Too much.
3. **Recognize Too Much:** If the medication is too much, too high in dosage, you will have signs of toxicity, and will bump your head on the top of that window – can't perform.
4. **Toxicity Timing: All Day Problems** - Toxicity may appear as Absolute: All day buzzing and can't think, just out the top of the window, feeling stoned, or ineffective all day.
5. **Toxicity Timing: Cyclic Top** - Toxicity may appear as Mercurial -- off and on -- with *hyperfocus* and subsequent *inability* to focus. This may still be toxic, not bipolar. Subtle, often missed, don't go up, - go down.
6. **More Symptoms Over the Top:** Confusion, disorientation, cognitive stress, anxiety, are all increased, while self-expression diminishes. Feels like ADHD all over again.
7. **Different Stimulant, Different Tops:** With *amphetamine* stimulants too high you might feel buzzed, an uncomfortable intensity, - with the *methylphenidate* products you may feel more "stoned and out of it."

Bottom of the Window - 7 Tips on Not Enough: Too Little

1. **The Meds Don't Work Long Enough: The Duration of Effectiveness [DOE] is not adequate:** Each stimulant drug has its own expected DOE, which will show the bottom.
2. **If you know the drug's DOE watch both the bottom and sides:** Each measurement will give you a specific fix for that geography, that time and tide. You will know where you are.
3. **It simply is not working.** Sometimes this one is missed because of trying to please.
4. **Onset appears too late:** Not enough right from the start. Expect at first with low doses.
5. **None of the IR [Immediate Release] last past noon, without significant side effects** such as: overfocused in the PM and a hard drop around 1-2PM.
6. **Use the DOE to teach adequacy of dosage to the patients.** If it is not showing an effect, focus and concentration are not corrected. Use the DOE with either IR or XR doses.
7. **Use DOE especially if mixing XR with IR:** Precision applies to every medication.