

Dr Charles Parker – Author: *New ADHD Medication Rules: Brain Science & Common Sense* – Morgan James and Koehler Books, NYC and VA.

Questions ~ .5 - 1hr Program

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1. What is ADHD? Is it real, imagined, or actually biologically based?
 - a. 2007 *Am J psychiatry*; up to 20% of school age children based upon the diagnosis of DSM4/5 reviewed 102 studies from N Africa, Europe, Russia, Middle East – ranging using those criteria to average about 9% to 15.9% in NC, LA, AL. but only of those about .5 are actually identified and treated.
 - b. One of the most thoroughly researched topics in medicine
 - c. Associated with a broad range of negative developmental outcomes including suicide, divorce, accidental death, drugs and alcohol.
 - d. Not ‘culturally based’ in N America
 - e. Heritability index: approx. 80% if both parents, 70% if one parent.
 - f. *Less than half of those dx are actually tx.* : Froelich 2007 *Archive Ped and Adol Medicine* ADHD isn’t over treated, but *under recognized and undertreated.*

2. How did your experience with SPECT brain imaging change your practice and your view of mind function?
 - a. SPECT even today is thought of as experimental though it’s been useful for more than 20 years clinically.
 - b. The brain is like the heart years ago... the mystery there was considered too deep to master – and emotions are even more private.
 - c. Brain science has evolved so rapidly many hold it in suspicion: Now we are engaged in The *Mind* Renaissance – Da Vinci [1400], Copernicus [1500], Galileo [1600], – *Index of Forbidden books/Church* - the repository of belief, against science. From math to tools they reconfigured how the solar system was put together, against the observations of the common man, and the pope at the time.
 - d. Brain imaging, though gross, is far more evidence than anyone is accustomed to, and still held in disregard by academia.

3. Why do so many have bias against ADHD meds and diagnosis?

- a. *Meds*: Stimulants – abuse potential, as a society recognizing what drugs can do to the thinking and developmental process. In the 60 and 70s we were seeing more, but only in the 80s did we ‘discover’ as a society Alcoholism, AA, and Codependency – my book ***Deep Recovery*** in 1992 addressed the serious oversights in treatment then and now.
- b. *Mind*: Considered willful because it’s *cognitive* not *affective*. *Thinking* is not examined routinely as there are few operational clinical parameters for assessing thinking clinically.
- c. The world from Freud on is focused, even today on feelings because the pain is obvious. Cognitive, mental, pain is not obvious.
- d. Since it is not obvious is it more likely to be challenged as a manifestation of will.
- e. The denial of thinking as biologically relevant, downstream from biology is the standard of care today: example avoidant personality is seen as a personality problem vs subset of ADHD.

4. What are the real problems with current diagnostic categories?

- a. Based upon *appearances*, not brain function. Clinicians defer to psychologists because some psychologists, not all, think more carefully about brain function. No one’s looking at the brain either diagnostically or clinically thus *New Rules*.
- b. Diagnosis not contextual, based upon changing reality, but based on seeking a label that works 24x7. The PFC deals with change the DSM finds reductionistic labels that encourage commoditization and homogenization of mental health.
- c. With complexity reduced by labels, complexity in response is denied.
- d. The greatest problem we face clinically is the Pervasive Denial Of Diagnostic Ambiguity with ADHD.
- e. ADHD should be AAD Attention Abundance Disorder, we treat the tip of the iceberg, not the 80-90% underwater. We are in the ocean, but forget that icebergs are composed of fresh water.
- f. Synchrony in change works well, but when it breaks down, and developmental arrest occurs, it’s because reality

changed and the person with ADHD can't effectively deal with the change.

- g. Labels are indeed categorical; the mind is functional, beyond fixed labels.

5. What are the problems with ADHD Medications? [these questions could easily fill an hour – I'll make them interesting]

- a. Pills must pass through the body to get to the mind.
- b. Metabolism effects dosage.
- c. Genetics effect dosage.
- d. Comorbid conditions depression, anxiety, bipolar and brain injury effect dosage.
- e. Immunity effects dosage.
- f. Breakfast effects dosage.
- g. Sleep effects dosage.
- h. Careless start up dosing
- i. Careless dosing over the duration of the day
- j. Careless dosing with other substances.
- k. Compliance effects dosage
- l. Specific choice of meds effects dosage.
- m. Past prescribing patterns from peds to adults effects dosage
- n. Bias against ADHD effects compliance

6. Why write *New ADHD Medication Rules*?

- a. Depression and ADHD occur in 2/3 of the cases but are uniformly overlooked as significant.
- b. Peds get the ADHD, Adult {sychs get the depression, Peds miss the depression, Adult Psychs often miss the ADHD. Child Psych often get both, but often treat only children.
- c. All this is occurring because both targets and meds are so filled with unpredictability and uncertainty because no one in the pharma industry has taken a stand that precision on dosing was necessary and predictable.
- d. Without "studies" they have nothing to support assertions, and therefore don't take a stand.
- e. Dinner meetings are over because some rogue speakers just filled in the gaps with their own speculation and cookie cutter strategies – and disdained available science.
- f. The public needs to know, no other book is available anywhere that takes the responsibility to outline the details.
- g. These challenges are global not simply North American.