

# ADHD MEDICATION

## THE COMPLETE PARENT'S GUIDE

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*Companion Guide*

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# How to Use This Guide

This companion guide is designed to sit alongside the ten-video ADHD Medication course. Each chapter corresponds to one video and expands on the core teaching with additional detail, practical strategies, and reference material that you can return to whenever you need it.

You do not need to read this guide cover to cover in one sitting. Watch a video, then read the corresponding chapter. Highlight what matters most to your family. Share specific sections with your partner, your child's teacher, or your prescriber. Print the strategies and stick them on the fridge if that helps.

The callout boxes throughout this guide are designed for quick scanning:

 **Key insight:** Blue boxes highlight the core principle — the one thing to remember if you remember nothing else.

 **How to implement:** Amber boxes provide specific, actionable steps you can take today.

 **Pro tip:** Green boxes share practical wisdom from twenty-five years of clinical experience.

 **Key anchor:** Lavender boxes anchor a key concept or phrase to carry with you.

 **Watch for:** Coral boxes flag important warning signs that need attention.

*This guide uses British spelling throughout: behaviour, centre, realise, colour, paediatric, organisation, programme, recognise.*

# Introduction

If you are reading this, you are already doing something important. You are investing time in understanding your child's medication — not just accepting a prescription and hoping for the best, but genuinely learning how it works, what it can and cannot do, and how to make informed decisions alongside your prescriber.

That matters more than you know.

Over twenty-five years of working with families navigating ADHD, I have seen one factor predict success more consistently than any other: parental understanding. When parents truly understand what is happening in their child's brain, they make better decisions, ask better questions, and become genuine partners in their child's treatment rather than anxious bystanders.

This ten-video course and companion guide will take you from wherever you are right now — whether you are considering medication for the first time, have just started, or have been using it for years and still have questions — to a place of genuine confidence. Not blind confidence. Informed confidence. The kind that comes from understanding the neuroscience, knowing your options, recognising what is working, and knowing exactly what to do when something is not.

Your child's brain is not broken. It is wired differently. And medication, when used well as part of a comprehensive treatment approach, is the most powerful single tool we have for helping that differently wired brain function at its best.

*Let's begin.*

# Video 1: The Wi-Fi Booster

*What Medication Actually Does Inside Your Child's Brain*

## Overview

In the video, we introduced the idea of your child's brain as a supercomputer running on unreliable Wi-Fi. This guide goes deeper into the neuroscience — how dopamine and norepinephrine work, why the reuptake pumps matter, and what it actually means when we say medication is a “multiplier.” Keep this beside you as you move through the series. Every concept we build from here rests on this foundation.

## Key Concept Explained

ADHD is fundamentally a condition of neurotransmitter regulation. The two key chemical messengers — dopamine and norepinephrine — are responsible for transmitting signals between neurons in the prefrontal cortex, the brain region that governs executive function: attention, impulse control, working memory, emotional regulation, planning, and organisation.

In ADHD, the reuptake transporters (the “pumps”) are overactive. They pull dopamine and norepinephrine back into the sending neuron too quickly, before the signal has been fully delivered to the receiving neuron. The result is an inconsistent, unreliable signal — the Wi-Fi that drops in and out.

Stimulant medications work by blocking these overactive transporters. Methylphenidate (Ritalin, Concerta) primarily blocks the dopamine transporter. Amphetamines (Vyvanse, Amfexa) both block the transporter and trigger additional dopamine release. Both approaches achieve the same outcome: more dopamine and norepinephrine remain

available in the synaptic gap for longer, strengthening and stabilising the signal.

This is why medication is a multiplier rather than just an addition. Research consistently shows that medication improves the effectiveness of behavioural interventions, school accommodations, and skills training. The landmark MTA study — following 579 children over 14 months — demonstrated that combined treatment (medication plus behavioural therapy) produced the best outcomes across all measures. Medication creates the neurochemical conditions that allow every other intervention to work more effectively.

Crucially, medication does not change who your child is. It does not add chemicals that were not already present. It does not create artificial focus or compliance. It restores the signalling system to a level where your child's own intelligence, creativity, and personality can function without constant interference from an unreliable connection.

## **Practical Strategies**

### **Strategy 1: Identify Your Wi-Fi Drop-Out Moments**

Spend one day observing your child and noting specific moments where the “signal drops.” These might include: losing track of a multi-step instruction, emotional reactions that seem disproportionate, starting tasks but abandoning them mid-way, forgetting something they were told moments ago. Write these down. This list becomes your baseline — the moments you'll use to assess whether medication is helping.

### **Strategy 2: Explain the Analogy to Your Child**

Children respond well to the computer analogy, especially older children and teenagers. Try: “Your brain is like a really powerful computer with dodgy Wi-Fi. The Wi-Fi keeps dropping out, and that makes everything harder — even though the computer itself is brilliant. Medication is like a

Wi-Fi booster. It doesn't change the computer. It just makes the signal stronger so everything works the way it's supposed to."

### **Strategy 3: Share the TV Remote Quote**

If your partner or a family member is uncertain about medication, share this: "Imagine sitting in front of the TV while someone else holds the remote. Channels change without warning. You can't choose what you watch. That's what it's like for our child without medication. Medication hands them the remote. The TV doesn't change. They just get to choose."



**Key insight:** Medication doesn't change the computer. It strengthens the Wi-Fi signal. And when the signal is strong, every other component — working memory, emotional regulation, impulse control, organisation — works better. That's why medication is a multiplier, not just an add-on.



**Key anchor:** Before medication, someone else held the remote. Medication hands it back to your child. The television doesn't change. The channels don't change. But your child gets to choose.

# **Video 2: What Medication Doesn't Do**

*And Why That Matters More Than You Think*

## **Overview**

In the video, we explored the limits of medication — not to discourage you, but to protect you from unrealistic expectations that lead to unnecessary disappointment. This guide expands on the four-leg table framework and gives you a practical way to assess where your child's treatment needs strengthening.

## **Key Concept Explained**

The most common reason parents conclude that “medication isn't working” is not because the medication has failed. It's because medication was asked to solve problems it was never designed to address. Medication targets the core neurochemistry of ADHD — the dopamine and norepinephrine signalling system. It improves attention, impulse control, and the capacity for self-regulation. These improvements are genuine and often dramatic.

But ADHD rarely travels alone. Eighty percent of children with ADHD have at least one comorbid condition — anxiety, learning disabilities, oppositional behaviour, depression, or sleep disorders. Medication does not treat these. A child whose reading difficulty persists after starting medication has not experienced a medication failure. They've experienced an accurate medication response — the ADHD symptoms improved, but the reading difficulty requires its own intervention.

Similarly, medication does not build the skills that years of ADHD may have prevented your child from developing. Study skills, social skills, emotional resilience, self-esteem, and organisational habits all need to be explicitly taught and practised. Medication creates the neurochemical

conditions that make learning these skills possible. It opens the door. Someone still needs to walk through it.

The four-leg table provides the framework for understanding this. Medication (~40%) is the strongest single leg. Home intervention (~20%) provides structure, communication, and connection. School intervention (~20%) provides accommodations and teacher understanding. Your child's own foundations (~20%) — sleep, exercise, nutrition, self-awareness — complete the picture. The landmark MTA study confirmed what clinical experience demonstrates daily: combined treatment produces better outcomes than any single intervention alone.

## **Practical Strategies**

### **Strategy 1: The Four-Leg Table Audit**

Rate each leg of your child's treatment on a scale of 1–10. Medication: Is the dose optimised? Is coverage adequate? Home: Are routines consistent? Is communication working? School: Are accommodations in place? Does the teacher understand ADHD? Child's foundations: Is sleep adequate? Is exercise regular? Does your child understand their own brain? Identify the weakest leg. That's where your next effort should go.

### **Strategy 2: Separate the Conditions**

If your child is on medication and still struggling, ask: which specific struggles remain? If attention has improved but reading hasn't, that suggests a learning difficulty that needs separate assessment. If behaviour at school is better but anxiety is worsening at home, the anxiety may need its own treatment. Medication treats ADHD. Everything else needs its own plan.

### **Strategy 3: Reframe “It's Not Working”**

Before concluding medication has failed, ask three questions. First: has the dose been properly optimised? (Many families judge medication by

the starting dose, not the therapeutic dose.) Second: is there a comorbid condition that needs separate treatment? Third: are the other three legs of the table being actively built? The answer usually reveals where the real gap is.



**Key insight:** Medication creates the conditions for learning, connection, and growth. It does not automatically produce them. The families who do best build all four legs of the treatment table — not just the medication leg.



**Watch for:** If your child seems flat, emotionless, or “like a zombie” on medication, the dose is wrong or the medication is the wrong fit. This is never acceptable. Tell your prescriber immediately. The goal is a child who is more themselves, not less.

# Video 3: Your Medication Options

*A Plain-English Guide to What's Available*

## Overview

In the video, we cut through the confusing maze of medication names and sorted them into three clear families. This guide gives you the detailed reference — including durations, costs, and South African availability — that you can take to your next appointment and use in conversations with your prescriber.

## Key Concept Explained

Despite the bewildering array of brand names, ADHD medications fall into just three categories. Understanding which family your child's medication belongs to is the single most useful piece of knowledge you can have when discussing treatment options.

The methylphenidate family (Ritalin, Ritalin LA, Concerta, Medikinet) works by blocking dopamine reuptake transporters. It is the first-line treatment for most children, with over seventy years of safety data. Short-acting Ritalin lasts 3–4 hours; Ritalin LA provides 6–8 hours; Concerta's OROS pump system delivers 10–12 hours of steady coverage.

The amphetamine family (Vyvanse, Amfexa) both blocks reuptake and triggers additional dopamine release. Vyvanse, as a prodrug, provides exceptionally smooth 10–14 hour coverage. These are often used for older children or when methylphenidate is insufficient.

Non-stimulants (Strattera/atomoxetine) work on norepinephrine rather than dopamine. They provide 24-hour coverage but take 4–6 weeks to reach full effect and are generally less powerful than stimulants. They are valuable when anxiety is prominent or stimulants are not tolerated.

A critical principle: if one medication family does not work, try the other before concluding that medication has failed. Approximately 70–80% respond to the first stimulant tried. For the remainder, switching families frequently produces a good result.

## **Practical Strategies**

### **Strategy 1: Know Your Child’s Medication Profile**

Write down: the medication name, the family it belongs to, the dose, the expected duration, and the time it is taken. Share this with your partner, your child’s teacher (duration is especially useful for them), and keep a copy in your phone. This simple act turns confusion into clarity.

### **Strategy 2: Prepare Questions for Your Prescriber**

Bring specific questions to your next appointment: “Is there a longer-acting option that might cover homework time?” “If this medication isn’t working well enough, what would you try next?” “Has my child tried both stimulant families?” These are the conversations that lead to better outcomes.

### **Strategy 3: Understand Generic vs. Brand**

In South Africa, Neucon OROS uses the same delivery technology as branded Concerta and is generally equivalent. Other generic methylphenidate formulations use different release mechanisms and results can be variable. If your child is switched to a generic and you notice a difference, discuss it with your prescriber. This is real clinical observation, not placebo effect.



**Key insight:** There are only three medication families. Knowing which family your child is in — and knowing the other options exist —

means you never have to feel lost when discussing treatment with your doctor.

★ **Pro tip:** If one medication doesn't work, it doesn't mean medication has failed. It means try the other family. About 70–80% of children respond to the first stimulant. For the rest, switching families often helps. Be patient. Finding the right medication is a process, not a gamble.

# Video 4: Starting Medication

*What a Proper Trial Actually Looks Like*

## Overview

In the video, we walked through the structured process of starting medication — titration, observation, and what “working” actually looks like. This guide gives you the tools to track your child’s response properly, communicate effectively with your prescriber, and avoid the most common mistakes families make during the first few weeks.

## Key Concept Explained

Titration is the process of finding your child’s optimal medication dose. It is not guesswork. It follows a systematic approach: start at the lowest effective dose, observe for one to two weeks, gather structured feedback from home and school, and adjust upward if the response is partial.

Most children require at least one or two dose increases before reaching their optimal level. The starting dose is designed to be tolerable and safe, not to be therapeutic. Judging medication by the starting dose is one of the most common errors families make — and it leads to premature abandonment of medications that would have worked beautifully at the correct dose.

A fair trial means spending at least two to three weeks at the optimised dose. For stimulant medication, effects should be visible from day one. If you see absolutely nothing on the first day at any dose, this particular medication may not be the right fit — discuss with your prescriber rather than waiting weeks in hope. For non-stimulants like Strattera, the timeline is completely different: four to six weeks of consistent use before judging effectiveness.

What “working” looks like is not a transformed child. It is the same child with more consistent access to their own capabilities. The pause button engages more reliably. Working memory holds information longer. Emotional responses are present but proportionate. The child can initiate and sustain tasks with less external support. Teachers often notice changes before parents do, because the structured school environment reveals the difference most clearly.

## **Practical Strategies**

### **Strategy 1: The First-Two-Weeks Diary**

Create a daily tracking sheet with these five domains: Focus (can sustain attention?), Mood (happy, flat, irritable?), Appetite (eating normally?), Sleep (falling asleep easily?), Rebound (what happens when medication wears off?). Rate each 1–10 every evening. Note anything unusual. Take this diary to every prescriber appointment during the titration period.

### **Strategy 2: Get Teacher Feedback Early**

Email your child’s teacher within the first week of starting medication. Keep it specific: “We’ve started a new medication. Over the next two weeks, could you let me know if you notice any changes in attention, task completion, emotional reactions, or social interactions?” Specific questions produce specific answers. “How’s he doing?” produces “Fine.”

### **Strategy 3: Don’t Judge Too Early**

The single most important rule: do not conclude the medication has failed until your child has spent at least two to three weeks at the optimised dose. If the starting dose produces partial improvement, that is good news — it means the mechanism is working and the dose simply needs increasing. Partial response at a low dose is one of the strongest predictors of excellent response at the correct dose.



**Key insight:** The starting dose is almost never the optimal dose. Titration is the process of finding the right level — and it takes 4–6 weeks. A fair trial means reaching the optimised dose, not judging by day three.



**How to implement:** Set up a simple daily diary before the first dose: Focus, Mood, Appetite, Sleep, Rebound. Rate each out of ten every evening. This single tool transforms your prescriber conversations from vague impressions to precise, actionable data.

# Video 5: Side Effects

*The Honest Conversation Every Parent Needs*

## Overview

In the video, we walked through the five most common side effects of ADHD medication and the specific solutions for each one. This guide gives you the complete reference — including the growth and cardiac safety data that helps you have informed conversations with anyone who raises concerns about long-term medication use.

## Key Concept Explained

Side effects from ADHD medication are common, predictable, and in the vast majority of cases manageable with straightforward adjustments. They are almost always dose-dependent — meaning they are related to how much medication your child takes, not to the medication itself being harmful. Reducing the dose typically reduces the side effect.

The five most common side effects are appetite suppression (affecting 50–80% of children on stimulants), sleep initiation difficulties (20–40%), rebound irritability when medication wears off (15–30%), emotional flattening at too-high doses (5–15%), and initial headaches or stomach discomfort (10–20%, usually resolving within the first two weeks).

The most feared side effect — the “zombie” presentation where a child appears flat, emotionless, and devoid of personality — is never an acceptable treatment outcome. It indicates the dose is too high or the medication is the wrong choice. It is easily corrected by reducing the dose or switching to a different medication. No child should remain on a dose or medication that produces this effect.

Growth impact: Meta-analyses show a temporary growth velocity reduction of approximately 1–2cm in the first 1–2 years of stimulant treatment. However, long-term follow-up studies through to adulthood consistently demonstrate that final adult height is not significantly affected. The temporary slowing is followed by a compensatory growth period.

Cardiac safety: Large-scale studies involving over 1.2 million patients have found no increased risk of serious cardiac events (heart attack, stroke, sudden death) in children and young adults taking stimulant medications. Routine monitoring of heart rate and blood pressure is standard practice and important, but the baseline risk is extremely low for children without pre-existing cardiac conditions.

## **Practical Strategies**

### **Strategy 1: The Appetite Action Plan**

Serve a substantial, protein-rich breakfast before medication kicks in. Pack calorie-dense snacks rather than a large lunch (nut butter on crackers, cheese, trail mix, smoothie in a thermos). Avoid battles at lunchtime — your child genuinely is not hungry. Have a substantial dinner ready for when appetite returns in the late afternoon. Track weekly weight rather than daily — most children compensate naturally. If weight loss persists beyond the first month, discuss timing or formulation changes with your prescriber.

### **Strategy 2: The Sleep Toolkit**

Ensure morning medication is taken early enough (before 7:30am for long-acting formulations). Implement consistent sleep hygiene: same bedtime, screens off 60 minutes before, cool and dark bedroom, a calming routine. If sleep remains difficult after two weeks, discuss

melatonin with your prescriber (0.5–3mg, 30–60 minutes before bed). Avoid caffeine, including in chocolate and soft drinks.

### **Strategy 3: Managing Rebound**

Note the exact time rebound hits (when mood drops, irritability spikes, or behaviour deteriorates). Share this timing with your prescriber — it tells them exactly when coverage runs out. Solutions include switching to a longer-acting formulation, adding a small short-acting afternoon booster, or managing the transition period with a snack, physical activity, and reduced demands during that window.

### **Age-Specific Notes**

#### **Young Children (5–8)**

Appetite suppression can be more concerning because younger children have less body mass reserve. Monitor weight closely and discuss caloric supplementation strategies if needed. Sleep difficulties are also common — melatonin at low doses is generally safe and effective for this age group.

#### **Primary School (9–12)**

Rebound typically coincides with homework time, creating daily flashpoints. A short-acting booster dose covering 3:00–6:00pm can transform the afternoon. Growth concerns often peak for parents during this period — the data is reassuring.

#### **Teenagers (13–17)**

Appetite suppression may contribute to self-image concerns, particularly in girls. Monitor for skipped meals becoming intentional rather than medication-driven. Teenagers are old enough to participate in side-effect tracking and should be involved in conversations with the prescriber.



**Key insight:** Side effects are a reason to adjust medication, not to abandon it. Every common side effect has a specific, practical solution. The one side effect that is never acceptable — emotional flattening or the “zombie” effect — means the dose or medication needs to change immediately.



**Watch for:** If your child seems flat, dull, or has lost their personality on medication, this is not a normal side effect to tolerate. Contact your prescriber immediately. The goal of medication is a child who is more themselves — not less.

# Video 6: The Coverage Question

*Why ADHD Doesn't Stop at 3pm*

## Overview

In the video, we introduced the backbone-and-booster strategy for extending medication coverage beyond the school day. This guide goes deeper into timing, practical implementation, and the specific situations where evening coverage makes the biggest difference. If your child's afternoons and evenings are consistently harder than their school day, this is the resource to keep beside you.

## Key Concept Explained

Most long-acting ADHD medications provide eight to twelve hours of coverage. For a child who takes their medication at 7am, that means coverage until somewhere between 3pm and 7pm, depending on the formulation and the individual child. Concerta typically lasts ten to twelve hours. Ritalin LA covers eight to ten. Vyvanse can stretch to twelve or fourteen in some children.

But your child's life doesn't end at 3pm. Homework demands focus. After-school activities require impulse control and social skills. Family dinner needs emotional regulation. Bedtime routines need the ability to follow sequential steps. And for teenagers, driving requires sustained attention and split-second decision-making.

The backbone-and-booster approach addresses this by using the long-acting medication as the reliable foundation, then adding a shorter-acting medication in the early afternoon to extend coverage seamlessly. The critical timing principle is overlap, not gap. The booster should be given as the backbone begins to fade — typically thirty minutes

before the usual crash point — so that coverage never drops out completely.

Many parents worry that afternoon stimulant medication will cause insomnia. This is sometimes true, but not always. The racing, dysregulated ADHD brain at bedtime is often a bigger sleep disrupter than a well-timed afternoon booster. I've had many families report that evening coverage actually improved sleep, because the child could follow the wind-down routine instead of bouncing off walls. If sleep is a concern, discuss timing and dose carefully with your prescriber — a very small booster dose is often sufficient for evening regulation.

## **Practical Strategies**

### **Strategy 1: Map Your Coverage Gap**

For five consecutive days, note the exact time your child's behaviour shifts in the afternoon. Look for: emotional volatility returning, inability to start homework, increased conflict with siblings, physical hyperactivity ramping up. This gives you (and your prescriber) a precise picture of when the backbone wears off. That time minus thirty minutes is your ideal booster window.

### **Strategy 2: The Handover Timing Test**

Once your prescriber adds a booster, track whether the transition is seamless. You should not notice a gap (a crash between the backbone fading and the booster kicking in) or a peak (a period where both medications are active simultaneously, which can cause over-stimulation). If either happens, adjust the booster timing by fifteen to thirty minutes in either direction. Small timing changes make a significant difference.

### **Strategy 3: The Weekend Question**

Ask yourself honestly: does my child's ADHD affect their weekends? If your child struggles with friendships, family outings, emotional regulation at social events, or completing any task that requires executive function, then weekends need coverage too. There is no clinical reason to restrict medication to school days. ADHD is a full-time condition and treatment can be too. Discuss a weekend strategy with your prescriber.

### **Strategy 4: The Homework Window**

If homework is a major flashpoint, time it to fall within the booster's coverage window. Give the booster, wait twenty to thirty minutes for it to kick in, then start homework. Combine this with a small snack (blood sugar helps), a clear workspace, and a realistic time limit. Homework done within the booster's active window is a different experience from homework done after the Wi-Fi has dropped out.

### **Age-Specific Notes**

#### **Young Children (5–8)**

Evening coverage may be less critical if homework demands are light. Focus on whether evenings and bedtime routines are manageable without a booster. If meltdowns are a nightly occurrence, coverage may help.

#### **Primary School (9–12)**

Homework demands increase significantly. An afternoon booster often becomes necessary in upper primary school. Also consider coverage for after-school sports and activities where focus and emotional control matter.

#### **Teenagers (13–17)**

This is where full-day coverage becomes most important. Longer school days, heavier homework loads, social complexity, part-time jobs, and driving all demand executive function well into the evening. Discuss comprehensive coverage with your prescriber.

 **Key insight:** ADHD is a full-time condition. Your child's brain doesn't stop needing support when the school bell rings. The backbone-and-booster strategy extends coverage to the hours that matter most to your family.

 **Key anchor:** Overlap, don't gap. The booster should kick in as the backbone fades — not after it's worn off. Thirty minutes of overlap prevents the crash that turns your afternoons into a battleground.

 **Pro tip:** Track the time your child's behaviour changes for five consecutive afternoons. That's your coverage gap. Bring it to your prescriber. Specific data leads to specific solutions.

# Video 7: Is It Working?

*How to Know If Medication Is Doing Its Job*

## Overview

In the video, we introduced the seven executive function dials and a practical system for monitoring medication effectiveness. This guide provides the complete framework, including a printable monitoring template, specific questions to ask teachers, and guidance on what ‘working’ actually looks like at different stages.

## Key Concept Explained

Medication monitoring is not about obsessively tracking every behaviour. It’s about systematically observing the areas of executive function that ADHD medication is designed to support, so you can communicate meaningfully with your prescriber.

The seven executive function dials correspond to the brain systems most affected by ADHD and most responsive to medication. The Pause Button (inhibitory control) governs impulse control — the ability to stop and think before acting. The School Bag (working memory) holds information in mind while using it. The Gear Shift (cognitive flexibility) allows transitions and adaptation to change. The Volume Dial (emotional regulation) modulates the intensity of emotional responses. The Starter Motor (task initiation) begins tasks without excessive external prompting. The Sat Nav (planning and organisation) breaks large tasks into manageable steps. The Filing Cabinet (memory retrieval) accesses stored information when needed.

When medication is working well, you don’t see perfection. You see improvement. The Pause Button engages more often — not every time. The School Bag holds more — but still drops things occasionally. The

Volume Dial has some middle settings — meltdowns still happen, but they're less intense and recover more quickly. Progress, not perfection, is the marker of effective medication.

Importantly, medication typically has the strongest effect on the Pause Button and the Volume Dial. Working memory and task initiation often show moderate improvement. Planning and retrieval may improve less dramatically and need additional skill-building. Understanding this helps you set realistic expectations.

## **Practical Strategies**

### **Strategy 1: The Three-Dial Daily Check**

Choose the three executive function areas most relevant to your child. Each evening, rate them from one to ten (1 = unmedicated baseline, 10 = best you've ever seen). Do this for two weeks before appointments. It takes sixty seconds per day and transforms your prescriber conversation from 'I think it's okay' to 'Here's what I'm seeing.'

### **Strategy 2: The On/Off Comparison**

Rate the same three dials during medicated hours (typically morning to mid-afternoon) and during unmedicated hours (evening, weekends if medication-free). This shows the medication's actual impact. A child who scores 7/10 medicated and 3/10 unmedicated is getting clear benefit. A child who scores 5/10 medicated and 4/10 unmedicated may need a dose adjustment.

### **Strategy 3: The Teacher Check-In**

Send your child's teacher a brief email every fortnight with four specific questions: (1) Can they sustain attention on instruction? (2) Are they completing classwork? (3) Are impulsive behaviours reduced compared to earlier? (4) Any new concerns? Teachers observe your child during

peak medication hours. Their data is invaluable. Don't assume they'll volunteer it — ask.

### **Strategy 4: The Timeline Pattern**

Look for patterns across your two-week data. Are mornings consistently better than afternoons (coverage issue)? Are Mondays harder than Fridays (routine and fatigue)? Are scores declining over time (possible tolerance or growth requiring dose adjustment)? Patterns tell a story. Bring the story to your prescriber.

 **Key insight:** 'He seems a bit off' isn't actionable. 'He's irritable every day from 3pm to 5pm' is. Specific observations lead to specific solutions. You are your prescriber's eyes and ears between appointments.

 **Key anchor:** You don't need to monitor all seven dials. Pick three. Rate them daily. Sixty seconds. Two weeks. That's the difference between guessing and knowing.

 **Pro tip:** Expect progress, not perfection. Medication makes the dials work better, not perfectly. If you're seeing 30–50% improvement in the Pause Button and Volume Dial, the medication is doing its job. The remaining improvement comes from the other three legs of the table.

# Video 8: When It's Not Just ADHD

*The Conditions That Travel Alongside*

## Overview

In the video, we introduced the concept of comorbid conditions — the invisible passengers that travel alongside ADHD. This guide goes deeper into each one, provides specific red flags to watch for, and explains what to do when you suspect something beyond ADHD is contributing to your child's struggles.

## Key Concept Explained

The eighty percent statistic is not bad luck. The same genes that contribute to ADHD also increase risk for anxiety, depression, and other conditions. The brain systems affected by ADHD overlap with systems that control mood, learning, sleep, and social processing. And years of ADHD-related struggle can create secondary problems — anxiety from repeated failure, depression from chronic criticism, oppositional behaviour from constant correction.

This has a critical implication for medication. ADHD medication targets the dopamine and norepinephrine systems that underpin attention, impulse control, and executive function. It does not target serotonin (involved in anxiety and mood), does not change how the brain processes written language (reading disabilities), and does not address learned behavioural patterns (entrenched opposition). Each condition needs its own intervention.

The practical question to ask is not 'Is the medication working?' but 'What exactly is the medication improving, and what remains?' If attention is better but reading hasn't changed, that's not a medication failure — it's a sign that a learning disability needs separate assessment.

If behaviour at school improved but anxiety is worsening at home, the anxiety needs its own treatment plan. Separating the conditions is the first step toward addressing them effectively.

## **Red Flags by Condition**

### **Anxiety**

Excessive worry about multiple things. Physical symptoms (stomach aches, headaches) without medical cause. Avoidance of anxiety-provoking situations. Difficulty separating from parents. Perfectionism that paralyzes rather than motivates. Racing thoughts at bedtime preventing sleep. These persist despite well-managed ADHD medication.

### **Learning Disabilities**

Reading, maths, or writing struggles that persist despite improved attention. A significant gap between obvious intelligence and academic achievement. Specific academic areas that are dramatically harder than others. Avoidance of particular tasks (reading, writing) despite willingness to try others.

### **Depression**

Persistent irritability or sadness lasting weeks (not hours). Loss of interest in previously enjoyed activities. Social withdrawal. Statements about worthlessness. Significant changes in sleep or appetite beyond medication effects. In children, depression often looks angry, not sad.

### **Sleep Disorders**

Hours of lying awake despite appropriate bedtime. Heavy snoring, gasping, or restless sleep. Extreme difficulty waking despite adequate hours. Daytime fatigue beyond what ADHD explains. Remember: poor sleep worsens every ADHD symptom.

## Practical Strategies

### Strategy 1: The Separation Exercise

Write down every area where your child is still struggling. Next to each one, ask: could ADHD medication reasonably be expected to fix this? Attention problems — yes. Impulse control — yes. A reading disability — no. Chronic worry — no. This exercise reveals which struggles belong to ADHD (and may need dose optimisation) and which belong to something else entirely.

### Strategy 2: The Professional Map

Different conditions need different professionals. Your paediatrician or psychiatrist manages medication for ADHD, anxiety, and depression. An educational psychologist assesses learning disabilities through psycho-educational testing. A clinical psychologist provides therapy for anxiety, depression, and complex presentations. An occupational therapist addresses sensory processing and motor coordination. Know who to ask for what.

### Strategy 3: The ‘Don’t Abandon’ Rule

If you suspect a comorbid condition, do not stop ADHD medication. The medication may be doing important work even if other problems remain. Instead, add the appropriate assessment or intervention while maintaining current treatment. Build, don’t demolish.

 **Key insight:** ADHD medication treats ADHD. Everything else needs its own plan. A child whose reading difficulty persists after starting medication hasn’t experienced a medication failure. They’ve experienced an accurate medication response — and a reading difficulty that needs its own intervention.

 **Watch for:** If your child is on well-managed medication and still struggling significantly, don't assume the medication isn't working. Ask: what exactly has improved, and what remains? The answer usually reveals an invisible passenger that needs its own attention.

 **Pro tip:** Before your next appointment, list every remaining struggle. Separate them into 'ADHD medication should help this' and 'This might need something else.' That single exercise can change the entire direction of your child's treatment.

# Video 9: Beyond Stimulants

*When Your Child Needs Teammates*

## Overview

In the video, we introduced four medication categories that can work alongside stimulant medication. This guide provides a more detailed reference for each one — how it works, typical dosing, side effects to expect, and what questions to ask your prescriber. Keep this guide for those moments when you need a clear, calm reminder of what each medication does.

## Key Concept Explained

The ADHD brain involves multiple neurotransmitter systems, and when comorbid conditions are present, the treatment picture becomes more complex. Stimulant medication (methylphenidate or amphetamine) targets dopamine and norepinephrine in the prefrontal cortex. But anxiety involves the serotonin system. Sleep involves the melatonin cycle. Hyperarousal and aggression involve the noradrenergic stress-response system. No single medication addresses all of these.

This is why ‘adding a medication’ is not a sign of treatment failure. It’s a sign of diagnostic precision. Your prescriber has identified which brain system needs support and is choosing the right tool for that specific system. The orchestra metaphor applies: a violin is magnificent, but it cannot play the bass line. Adding a cello doesn’t mean the violin has failed. It means the music requires both.

Importantly, these medications work alongside stimulants, not instead of them. The stimulant continues to do its job on the ADHD core — attention, impulse control, working memory. The additional medication

targets the specific comorbid condition. They operate in parallel, addressing different aspects of your child's neurology.

## **Medication Reference**

### **SSRIs (Fluoxetine, Sertraline, Escitalopram) — For Anxiety and Depression**

Work by increasing serotonin availability. Take four to six weeks for full effect. Common initial side effects: nausea, headaches, sleep changes (usually temporary). Some children experience increased anxiety in the first one to two weeks before improvement — this is expected. Work well alongside stimulants (different brain systems). Typical starting dose is low, increased gradually. Do not stop suddenly — must be tapered under medical guidance.

### **Melatonin — For Sleep Initiation**

A naturally occurring hormone, not a sedative. Helps signal the brain that it's time for sleep. Give thirty to sixty minutes before desired bedtime. Start with 0.5–1mg (young children) or 1–3mg (older children). Timing matters more than dose — more is not better. Helps children who lie awake unable to fall asleep, especially those with a delayed body clock. Does not help with frequent night waking or poor sleep quality (these need different investigation). Generally very safe for short and medium-term use.

### **Clonidine (Dixarit) — For Impulsivity, Aggression, and Hyperarousal**

An alpha-2 agonist that reduces stress-response system activity. Helps: impulsivity not fully managed by stimulants, physical aggression, constant 'revved up' state, racing thoughts at bedtime. Often given at bedtime where it supports sleep and calmer mornings. Side effects: sedation (especially initially), dizziness, dry mouth. Must not be stopped

suddenly — can cause rebound blood pressure spike. Must be tapered under medical supervision.

### **Atypical Antipsychotics (Risperidone, Aripiprazole) — For Severe Emotional Volatility**

Used only when emotional storms are severe and other treatments have not been sufficient. Explosive aggression, prolonged violent meltdowns, and mood instability that disrupts daily functioning. Require careful monitoring: weight gain and metabolic changes (blood sugar, cholesterol) are potential side effects. Not first-line. Not common. But for the small percentage who need them, they can be transformative. Never prescribed without comprehensive assessment.

 **Key insight:** Adding a medication is not a sign of failure. It's a sign of precision. Different brain systems need different support. The stimulant handles the ADHD core. The teammates handle the travelling companions. Different instruments, same orchestra.

 **Key anchor:** Before starting any new medication, ask three questions: What specific problem is this targeting? How long before we see results? What side effects should I watch for? Write down the answers. You'll need them.

 **Pro tip:** SSRIs need four to six weeks. Melatonin needs the right timing more than the right dose. Clonidine must never be stopped suddenly. These are the three facts that prevent the most common parental frustrations with additional medications.

# Video 10: The Whole Picture

*Bringing It All Together*

## Overview

This is the final companion document in the series. In the video, we introduced the four-leg table and addressed the most common medication myths. This guide provides the complete framework for assessing your child's treatment, a myth-busting reference you can share with family members, and the audit tool that will guide your next steps.

## Key Concept Explained

The four-leg table is not a metaphor I invented for fun. It's grounded in the largest ADHD treatment study ever conducted — the MTA study — which followed nearly six hundred children over fourteen months. The study found that medication alone was more effective than behavioural therapy alone for core ADHD symptoms. But the best outcomes came from combined treatment: medication plus behavioural intervention plus school support plus lifestyle optimisation.

The percentages are approximate and will vary by child, but they provide a useful framework. Medication contributes roughly forty percent of the overall improvement. It is the strongest single intervention because it addresses the neurochemical foundation of ADHD. But forty percent leaves sixty percent of the picture unaddressed. Home strategies (structure, communication, routines) contribute roughly twenty percent. School accommodations and teacher understanding contribute roughly twenty percent. And your child's own foundations — sleep, exercise, nutrition, self-understanding — contribute roughly twenty percent.

The practical power of this framework is diagnostic. If your child is struggling, the four-leg audit tells you where to look. Rate each leg from

one to ten. Find the weakest leg. That's where your next effort goes. A family that has the medication perfectly optimised but has no school accommodations is operating on three legs. A family with brilliant school support but chaotic home routines is also on three legs. The table needs all four.

## **Myth-Busting Reference**

### **Myth: Medication Changes My Child's Personality**

Reality: If your child seems like a different person — flat, dull, robotic — the dose is too high or the medication is wrong. Properly dosed medication doesn't change personality. It reduces the noise so your child can be who they already are, more consistently. The boy who told me 'I can think now — before, my brain was too noisy' wasn't a different person. He was himself, finally heard.

### **Myth: Medication Is Addictive and Leads to Substance Abuse**

Reality: The evidence shows the opposite. Multiple longitudinal studies demonstrate that children with ADHD who are treated with medication have lower rates of substance abuse in adolescence and adulthood compared to those who are untreated. Untreated ADHD is the risk factor, not the treatment. Untreated impulsivity and the need for self-medication drive substance use. Treated ADHD reduces that drive.

### **Myth: Natural Alternatives Work Just as Well**

Reality: Omega-3 supplements have an effect size of 0.2 to 0.3 — a barely noticeable improvement. Stimulant medication has an effect size of 0.8 to 1.2 — one of the most effective treatments in all of medicine. Dietary changes, exercise, and good sleep are important foundations (leg four of the table), but they cannot replace medication for moderate to severe ADHD. By comparison, glasses for poor vision have an effect size of

about 1.0. Would you tell a short-sighted child to eat more carrots instead of wearing glasses?

### **Myth: Children Grow Out of ADHD**

Reality: Approximately sixty to seventy percent of children with ADHD continue to meet criteria in adulthood. Symptoms may change — hyperactivity often decreases while inattention and executive function challenges persist — but the condition rarely disappears entirely. Many adults learn to compensate, but the underlying brain difference remains.

## **Practical Strategies**

### **Strategy 1: The Four-Leg Table Audit**

Rate each leg from one to ten. Medication: Is the dose optimised? Is coverage adequate for your child's day? Are you monitoring effectively? Home: Are routines consistent? Is communication with your child about their brain open and positive? Are strategies from this course being implemented? School: Are accommodations formally in place? Does the teacher genuinely understand ADHD? Is the teacher your partner or your adversary? Your child's foundations: Is sleep adequate (nine to eleven hours for school-age children)? Is exercise happening regularly? Does your child understand their own brain? Find the weakest leg. That's your next focus.

### **Strategy 2: The Struggling vs Suffering Check**

Ask yourself honestly: is my child struggling or suffering? Struggling means working hard, hitting bumps, needing support, but growing. Suffering means overwhelmed, failing, friendless, hopeless. If your child is suffering despite treatment, something is missing — a leg is weak, a comorbidity is unaddressed, or medication needs optimisation. Suffering is not acceptable. Struggling is part of life.

### **Strategy 3: The Family Myth Response**

You will receive unsolicited advice. Here are scripts for common situations. For ‘You’re drugging your child’: “We’re treating a neurological condition with evidence-based medicine, just like you’d treat diabetes or asthma.” For ‘Have you tried cutting out sugar?’: “We’ve discussed nutrition with our specialist. ADHD is a brain condition, not a dietary one.” For ‘He just needs more discipline’: “Actually, ADHD is a neurological condition that affects impulse control. More discipline doesn’t fix brain chemistry.”



**Key insight:** The four-leg table: Medication (~40%), Home (~20%), School (~20%), Your child’s foundations (~20%). Find the weakest leg. Strengthen it. That’s where progress lives.



**Key anchor:** The goal is not a perfect child. It’s a child who is struggling — not suffering. Struggling is part of life. Suffering is not acceptable. If your child is suffering, something in the four-leg table needs attention.



**Pro tip:** Your child’s brain is not broken. It is wired differently. And you are exactly the parent they need. Progress, not perfection. You’ve got this.

# Quick Reference Summary

## *The Ten Videos at a Glance*

**Video 1: The Wi-Fi Booster:** Medication strengthens the brain's signal. It doesn't change the computer — it makes the Wi-Fi reliable.

**Video 2: What Medication Doesn't Do:** Medication provides ~40% of the solution. The other 60% comes from home, school, and your child's own foundations.

**Video 3: Your Medication Options:** Three families: methylphenidate, amphetamine, non-stimulant. If one fails, try the other before giving up.

**Video 4: Starting Medication:** The starting dose is not the optimal dose. Give the titration process 4–6 weeks. Track everything.

**Video 5: Side Effects:** Common, predictable, manageable. The zombie effect is never acceptable — change the dose or medication immediately.

**Video 6: The Coverage Question:** ADHD is full-time. Backbone-and-booster extends coverage. Overlap, don't gap.

**Video 7: Is It Working?:** Pick three executive function dials. Rate them daily. Sixty seconds. Two weeks. Bring the data to your prescriber.

**Video 8: When It's Not Just ADHD:** 80% have a comorbid condition. Separate the conditions. Each one needs its own plan.

**Video 9: Beyond Stimulants:** Additional medications are teammates, not replacements. Different brain systems need different tools.

**Video 10: The Whole Picture:** Four-leg table. Find the weakest leg. Strengthen it. Struggling, not suffering. Progress, not perfection.

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