Need We Drug America's Children?
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Medicine

Need We Drug America's Children?

Skeptics question the existence of Attention Deficit Hyperactivity Disorderand the pattern of giving powerful psychotropic drugs to young children

A first-year medical student offers his personal observations and investigations into the controversial issue of ADHD. By Trishul Siddharthan, Florida

I first encountered attention def-icit Hyperactivity Disorder in the fourth grade in one of my classmates. Due to his impulsiveness, he made simple mistakes that led to difficulty in school and caused disciplinary problems. He would not follow classroom rules. Frequently, he often blurted out answers without raising his hand. I remember the ashamed look on his face when he was chastised in front of the class. Though his attention span was limited, he was a bright student with a passion for science and a dream of working for NASA. Concerned about his hyperactivity, his parents took the 10-year-old to a doctor who diagnosed him with ADHD and prescribed a drug called Ritalin (the chemical methylphenidate). I can still remember the white pill in his hand. The drug dramatically changed his behavior. A once playful and curious boy became docile and unsettlingly focused.

I now feel that my friend's disinterest and difficulty with class work stemmed from not being fully engaged and challenged by the school system. Unfortunately, Ritalin did not cure his problems. Although his parents were very active in school affairs and showed a strong interest in their son, I recently found out he has become heavily involved with drugs over the years and now faces problems with the law.

From fourth grade on, I had frequent opportunities to observe the disorder in other students, the many prescription medicines used to combat it, and the abuse these powerful drugs invited. In high school I saw classmates share pills. In college I witnessed a strong underground market for methylphenidate, sold as Ritalin,

Methylin, Concerta and other brand names.

Diagnosing ADHD

ADHD, once known as just Attention Deficit Disorder or ADD, is characterized by persistent inattention and/or hyperactivity. Its symptoms include forgetfulness, lack of impulse control and distractibility. It has been a controversial diagnosis for adolescents. Arguments for and against it are vehement, and obtaining unbiased information is difficult. Many critics argue that the definition of the disease is too broad, and that the symptoms can be a result of other problems.

Currently the mechanism of diagnosis for ADHD follows a list of 22 symptoms (www.cdc.gov/ncbddd/ADHD/symptom.htm) of inattentiveness and hyperactivity such as: "difficulty sustaining attention in tasks or play activities," "fidgets with hands or feet or squirms in seat," "easily distracted," "blurts out answers," "talks excessively" and "loses things." If the majority of these conditions are met, a child may be diagnosed with ADHD. It is this subjective diagnosis which raises questions as to the reality of the psychological condition.

The diagnosis of ADHD is relatively new. Only in 1994 was the condition fully described in the DSM-IV, the reference book for psychological disorders. The prescribing of methylphenidate has been an economic boon to the pharmaceutical industry, with 40% of pediatric psychiatry references pertaining to ADHD occurring within two years of the revised definition. In 2005, Adderall, an amphetamine drug prescribed for ADHD, accounted for half of Shire Pharmaceutical's US$1.3 billion in sales.

Hyperactivity and attention deficit are hallmarks of normal adolescence. At some point in my 16 years of formal education, I have found myself exhibiting the majority of these criteria. I can remember squirming in my seat throughout school; I still do so in medical school. Dan P. Hallahan and James M. Kauffman, in their book Exceptional Learners: Introduction to Special Education, have argued that the increase in diagnosis of ADHD is due to overly general diagnostic criteria which allow any child with persistent unwanted behaviors to be classified as having ADHD. Some experts claim nine percent of all children have ADHD. Misdiagnosis of ADHD has been an issue among health professionals, as ADHD symptoms are easily confused with a variety of other problems, including poor vision, inadequate caregiving or even simple lack of sleep. As with most medical conditions, there are both genetic and environmental factors. Increased sugar intake and caffeine in

students' diets is one suspect. Many of the effects of caffeine on the central nervous system parallel those of ADHD, including decreased attention and hyperactivity.

Most experts would not agree that ADHD is the result of bad parenting. But parents with busy schedules can easily miss the early signs of difficulty in school or disciplinary problems. It is crucial to promptly correct these earlier difficulties and especially to reinforce the child's self-esteem, which invariably suffers in a child who has ADHD.

Treatment by drugs

The cause of greatest alarm for ADHD lies not in the diagnosis but in the treatment. Both methylphenidate and the amphetamines in Adderall are listed by the US Drug Enforcement Agency as Schedule II substances, meaning they have a high potential for abuse and induced effects. That list includes cocaine, opium, oxycodone and a host of other powerful and addictive drugs. Over the past decade, the pharmaceutical market has seen a dramatic increase in drugs marketed to treat ADHD. Testifying before the House Subcommittee on Early Childhood, Youth and Families in May, 2000, then DEA Deputy Director Terrance Woodworth stated that methylphenidate prescriptions increased 846%--from 1,768 kilograms in 1990 to 14,957 in 2000. Amphetamine prescriptions increased 2160%--from 417 kilograms to 9,007--during the same period. The majority of these drugs were prescribed for childhood ADHD. The US accounts for approximately 90 percent of total world manufacture and consumption of methylphenidate. In high schools and colleges across America, methylphenidate is regarded as a quick aid for studying and last-minute cramming. For a few dollars, or even for free, many diagnosed students happily share a pill with a schoolmate. Along with a stimulant drink, it can keep a student alert all night before an exam. I have witnessed this as an increasingly common practice. An Indiana University study of 44,000 high school students found that about seven percent of those surveyed admitted to Ritalin abuse at least once. Of those students, 2.5 percent took it monthly or more often.

Potential for abuse

Even among Asians, who have the lowest rates of substance abuse, taking methylphenidate and its many derivatives are a popular way to get a competitive edge in school. Educators and ethicists are now debating whether these drugs may give unfair advantage to some students in the academic field, just as performance-enhancing drugs do for athletes. These are smart students seeking entrance into medical or other professional schools. Their family upbringing is similar to mine; yet to them, taking an illegal drug to help study is somehow

acceptable compared to taking one just to get high.

After taking methylphenidate, students become intensely concentrated on the work in front of them, oblivious to their surroundings. Frequently, I have had to address a drugged classmate multiple times to get his attention, then watch him mechanically go back to studying. The next day, after the extended-release tablets had worn off, he would sleep for hours all through the day. With the abuse of methylphenidate comes weight loss and sleep disorders.

Until recently, the effects of this drug were thought to be short term; but now there is evidence of long-term impact. In July 2001, the Connecticut legislature unanimously passed a measure prohibiting school officials from recommending psychiatric drugs of any kind.

The broader problems

Proponents of ADHD point to the positive results of medicating diagnosed individuals. Many students do perform better in school as a result. I have encountered students whose lives were dramatically improved by proper diagnosis and treatment. At the same time, a once obscure disorder has become a trend in mainstream America, with many parents--increasingly too busy to raise their kids--medicating them for what the rest of the world regards as normal behavior. In my time in secondary school I witnessed many parents attempt to explain away their child's poor performance with a diagnosis of ADHD--often encouraged by a teacher, counselor or school official. I am constantly reminded of the dependency some of these students developed. Due to its wide availability and its labeling as a "study" drug, methylphenidate remains one of the most popular and easily obtained controlled substances in America.

The bottom line is that the issues associated with ADHD underscore a larger problem in our society: the tendency to seek quick fixes for complex problems. Difficulties in child rearing cannot be solved with a pill. The United States' poor showing in education indices--from reading to mathematics--cannot be blamed on ADHD, given that the US accounts for 90 percent of the world's methylphenidate consumption. Parents, educators and legislators must look beyond this short-term remedy and begin addressing the broader problems that are really to blame. PIpi