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Raising Children in an Age of Ritalin

Bioethics and Law Forum*

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My young daughters are smart. They have a lot of potential. They are also easily distracted, impulsive, and fidget constantly. If they were taking Ritalin, it is highly likely that they would be less easily distracted, perform better academically, and perhaps, as a result, become more accomplished adults. So why not place my children on Ritalin? Is there anything wrong with placing my children on Ritalin if they are suffering from nothing other than immaturity?

By recent estimates, there may now be as many as 4 million school-age (5–13 years old) children in the United States taking Ritalin or a similar prescription stimulant for the treatment of attention-deficit disorder (ADD) or attention-deficit hyperactivity disorder (ADHD). While drugs have been prescribed to treat hyperactive children since the 1930s, use in the last decade has exploded. By one estimate, Ritalin production increased by at least 700% in the period from 1990 to 1998. This is not necessarily a cause for concern if the condition has been traditionally underdiagnosed. That is to say, a dramatic increase in drug prescriptions, however large, is not a cause for alarm if they are used safely and effectively to treat a genuine medical condition.

The question posed here: Should it matter if a child is suffering from ADD or ADHD when considering medicating him or her with Ritalin or the like? Is there something wrong with giving children Ritalin, assuming a physician could be found to prescribe it if he or she does not suspect the child is suffering from ADD or ADHD; that is, purely for mental enhancement as opposed to mental/behavioral therapy?

First, there is a great deal of skepticism regarding children and Ritalin in this country due in part to the difficulty of diagnosing ADD and ADHD. According to the Diagnostic and Statistical Manual of Mental Disorders, the reference work for the diagnosis of psychiatric disorders, a person suffering from ADHD is (seriously) inattentive and hyperactive and/or impulsive, has been so for at least 6 months, and the person's behavior significantly impairs function in more than one setting (ie, home, school, or work). However, virtually all children manifest these symptoms at times in varying degrees of seriousness. The difficulty is determining, in the less obvious cases, whether a child is genuinely suffering from ADD or ADHD or is simply behaving like a child. Some attempts have been made to diagnose ADD or ADHD by trial; prescribing Ritalin to see whether distractibility is reduced and focus improved. This method of diagnosis is fundamentally flawed because an appropriate dosage of Ritalin has a calming or focusing effect on everyone, regardless of whether one is suffering from ADD or ADHD. The challenge of a diagnosis should provide a greater stimulus for an accurate diagnosis rather than a valid reason for skepticism.

In addition to an appropriate diagnosis, a medicine's safety, efficacy, and side effects are always of paramount concern when deciding whether to use any given drug. Here, safety seems not to bar such usage. Ritalin and Ritalin-like stimulants have been used productively for some 6 decades with very few side effects beyond insomnia if the drugs are taken too close to bedtime. Similarly, there is no notable evidence that child dosages lead to physical addiction as in adults.

Another frequent objection about children taking Ritalin purely for mental enhancement is that those children somehow skirt the struggle to become educated. This is thought to be a problem because it is believed the effort to become educated is valuable in and of itself. Children are not educated solely because we want them to learn particular facts but also because there is value in the learning process, working things out, and discovering. Thus, this objection is likewise without merit. Ritalin does not provide a short cut to education—there is no short cut. Instead, children using Ritalin are simply able to participate more fully in the education process because they are able to focus and, consequently, they attain greater educational achievement.

A more worrisome objection to prescribing Ritalin for enhancement as opposed to medical therapy is distribution. Ritalin, at least at this time, requires a prescription, is relatively expensive, and knowledge of its benefits unknown to many communities. The concern is that the di-

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vide between the haves and the have-nots will increase in the future, as the haves are able to procure off-label prescriptions for Ritalin in an effort to wring even more from their children's educations than their poorer counterparts, who may lack such access or may legitimately need the medication to treat ADD or ADHD. Such actions will increase the already vast societal divide. The response to this objection must parallel the solution to the existing discrepancy in healthcare and education access generally. It is up to us, through our legislators, to ensure that access and advantages make their way to all.

In spite of the weaknesses of these common objections, the reason many parents are uncomfortable with the idea of enhancement by Ritalin is likely as much visceral as it is rational. While we accept that vitamin supplements and exercise can enable our children to perform better, those methods of enhancement seem somehow radically different than years of drugging a child with prescription medication. Yet if advances in biotechnology and human health are as successful in the coming decades as they are predicted to be, we might one day wonder how we ever got along without these stimulants.