

One Pill Makes You Smarter: An Ethical Appraisal of the Rise of Ritalin

The statistics at least *seem* alarming. The production of Ritalin, an amphetamine derivative used for the treatment of attention deficit disorder in children (and, lately, in adults as well), has risen a whopping 700 percent since 1990. According to figures given by Lawrence Diller in *Running on Ritalin*, over the decade, the number of Americans using Ritalin has soared from 900,000 to almost 5 million—the vast majority children from the ages of 5 to 12, though there is a significant rise in Ritalin use among teens and adults as well. No comparable rise is reported in other countries, though a much smaller surge has taken place in Canada and Australia. In Virginia Beach, Va. (perhaps the most egregious example), 17 percent of fifth-grade boys were taking Ritalin in 1996 to control behavior problems and improve school performance. (Boys on Ritalin outnumber girls in a ratio of 3.5 to 1; when I was recently complaining to another mother about my own son's academic difficulties, she said simply, "Welcome to the world of boys.")

Stimulants have been used to treat behavior problems in children since 1937; Ritalin itself appeared on the market in the 1960s to treat what was then called "hyperactivity"—impulsive, disruptive behavior by children who just "couldn't sit still." In recent years, however, the root problem has been identified as "attention deficit disorder" (ADD), either with or without attendant hyperactivity.

Symptoms of ADD, according to the standard survey used in its diagnosis, include: "often fails to give close attention to details or makes careless mistakes in schoolwork," "often has difficulty organizing tasks and activities," and "often avoids, dislikes, or is reluctant to engage in tasks that require mental effort (such as schoolwork or homework)." Symptoms of ADD-H (the variant with hyperactivity) include: "often fidgets with hands or feet or squirms in seat" and "often has difficulty playing or engaging in leisure activities quietly." Ritalin, by most accounts, is remarkably effective in getting such children to settle down and pay attention, with resultant (at least short-term) gains in parental sanity and academic achievement.

The fear, stated quite baldly, is that as a society we are drugging our children in ever-larger numbers to get them to conform to adult expectations. Dislikes

homework? Makes careless mistakes? Squirms in seat? To many it seems that we are drugging our children to get them to stop being *children*. I myself feel profoundly troubled by the rise of Ritalin—and by my own temptation to use it for my child, who, yes, makes careless mistakes and has been known to fidget. But, I will argue, it is surprisingly difficult to pinpoint any justifiable sources of discomfort here—both harder than one might think, and more illuminating. The effort to do so will lead us into an exploration of a range of issues about how we view our children and ourselves.

Here, then, are some possible responses to our concerns about the rise of Ritalin, followed by some speculations about the deeper—and legitimate—fears that fuel these concerns.

Rationales for Treatment

On some accounts, the rise in Ritalin simply reflects our commendably growing willingness to treat a serious and common disorder that has too long been left untreated. That there is soaring use of any drug is not itself a problem, if the drug is treating a genuine medical condition that responds favorably to treatment. If there is some real disorder in the area of children's brains that controls their ability to pay attention (current research is focusing on the prefrontal cortex), and this disorder is causing problems in school and home, and it can be easily treated, *shouldn't* it be treated? Why should children have to struggle with their schoolwork, and parents struggle with discipline, if the root cause of disappointing academic performance and poor behavior is a medical one that can be easily treated? On one expert's estimate, attention deficient disorder is even now underdiagnosed, and so we should expect—and welcome—a further doubling of Ritalin use in response.

However, it is unclear that there really is any one, clearly identified "thing" that "is" attention deficit disorder. Diller argues persuasively that when parents or doctors speak of a child as "having" ADD, this tends to mean only that the child in fact scored positively on a certain number of questions on the kind of survey described earlier. Certainly diagnosis of ADD

is inexact, to say the least—often based largely on reported frustration by parents and teachers, sometimes made (as admitted by some teachers I've spoken to in my own local schools) by prescribing Ritalin on a trial basis and seeing if it works.

The trouble with the latter approach is that Ritalin almost always "works," in that it almost always enhances performance, at least in the short term (Diller reports that there is no evidence of long-term improvement in children taking Ritalin). According to one study cited by Diller, "stimulants had essentially the same effects on normal children as on children with attention or behavior problems." Diller notes an increasing amount of what has been called "diagnostic bracket creep," as the criteria for diagnosis become ever more loose and generous, allowing more borderline ADD children to benefit from drug treatment.

Now, it can be argued that it shouldn't matter whether children receiving Ritalin have some underlying "brain disorder" that causes inattention, or whether they are inattentive for other, less physiologically based reasons. Why is the *cause* of a condition relevant to whether or not we have reason to try to treat it? For example, if parents are debating whether or not to treat an abnormally short child with growth hormone, David B. Allen and Norman Fost have argued that it shouldn't matter whether the child's height is caused by a hormone deficiency or by his genetic endowment: What should matter is whether this is causing a problem for him, and whether it can be successfully treated.

With the diagnosis of attention deficit disorder so elastic, however, one begins to wonder whether the

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"disorder" in question is simply that the child places at the lower end of the spectrum for behavior or achievement—that is, that parents, clinging stubbornly to Lake Wobegon fantasies, insist that all children generally and their own children in particular should be "above average," or certainly not below average. (I have discovered from my own experience that teachers are also quick to suggest an ADD evaluation for a child with any academic difficulties.) If attention or behavior problems interfere with a child's achieving his or her "full potential," parents and teachers may be increasingly tempted to turn to medication, even where this can mean not just allowing their children to perform "normally," but raising them significantly above the norm. Diller mentions one student whose use of

Ritalin allowed him to become his high school's valedictorian: Off the drug, he still performed well, but his grades slipped, from straight A's, to A's intermingled with B's.

Some of us will be troubled by using Ritalin in such cases. But why shouldn't every child be able to use whatever means are available to improve his or her performance, whatever his starting point? If we were to raise poor performers to the mean, but refuse to raise average performers above the mean, this could seem unfair to the superior performers. Why shouldn't they have a chance at enhancement, too?

Ritalin as a Means of Enhancement

As Ronald Cole-Turner points out, in his article in this issue, most of us are already "enhancement enthusiasts." We not only strive to improve our children all the time, but would criticize parents who neglected to do so. If we give children Ritalin to enhance their academic performance—well, don't we send them to school in the first place for the same reason? It doesn't seem all that problematic to want our children to be more attentive, more responsive, better behaved, better able to learn: Isn't better, by definition, *better*? Cole-Turner argues, however, that while the goal of enhancement may be a legitimate one (I will raise doubts about this below), we need also to look at the means. Means *do* matter.

First, some means may be problematic in themselves, including the use of drugs. A friend with whom I was discussing the rise in Ritalin use voiced the reactions of many in saying, "Putting kids on drugs? Uh-uh." Now, drugs of any kind are often attended with a myriad of negative (and perhaps not yet discovered) side effects. But stimulants like Ritalin have been used to treat behavior problems in children for six decades with few observed ill effects. Ritalin causes insomnia, which can be avoided by not taking it in the evening; some children experience suppressed appetite. But the vast majority experience no distressing side effects at all.

The term "drugs" generally carries with it a stigma: When we think of "children on drugs," we think first of illegal drug use; when we talk about "drugging our children," we visualize children wandering through the day in a dopey, feel-good haze. It is important to free Ritalin from such unwarranted associations. Its use is legal, although controlled, and, far from inducing a fuzzy "drugged" state, it works to increase the ability to pay attention. With Ritalin, children don't "tune out," but "tune in." Or so we might claim.

Second, as Cole-Turner argues, some means to an end may be valued for their own sake and in their own right—either because they also represent ends that we value, or because we value reaching the end only after an experience of striving and struggle. If we choose a



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"quick fix" to solve our problems and achieve our goals, we may end up achieving different goals altogether, or, at the least, give up the long and ultimately more rewarding journey to our destination. In the case of Ritalin, the fear is that we will be content to give "problem children" a couple of little pills every day, rather than put in the extra effort as parents and teachers to reach them and teach them, to help them learn and grow in a more messy and non-medicalized way. Specifically, the fear is that we will see Ritalin as a means of bypassing tough and loving parental discipline or real (and expensive) commitments to shouldering the rising costs of effective public education.

Now, clearly we value parental love and discipline and the long journey of education as ends in themselves, not just as means to producing more successful children. Focusing for the moment on education, we don't send children to school simply to get them to acquire a certain body of knowledge and master a certain body of skills, but because the process of learning is itself valuable. I still remember the thrill the first time I really "got" long division. Or the shock of joy with which I first learned, from my high school American history teacher, that there really are two sides to every question. We may worry that Ritalin provides an easy way out of facing the challenge—and reward—of truly educating our children. For teachers

who can teach and classroom environments in which children can learn cost vastly more than daily doses of Ritalin.

To this concern about Ritalin, I have two responses. First, Ritalin could be defended as a means, not of bypassing the journey of education, but of permitting certain children to engage in the journey more fully, to

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pay attention to the journey in all its richness. Ritalin doesn't substitute for learning; it at best assists in providing one of the preconditions for learning—the ability to pay attention to what is being taught. Ritalin or no Ritalin, we will still need to teach our children, both how to behave and how to learn, in the most creative ways possible.

This suggests, second, that when it comes to parents and to teaching, we do not need to fear that we will take the easy way out, because, quite simply, there is no easy way out. Cole-Turner points out correctly that while new means "may relocate our human struggle,

they do not eliminate it." Even if we are what Gerald Klerman has called "pharmacological calvinists," who reject drug-based solutions as too easy, who value the hard way just because it's hard, this gives us no reason to resist Ritalin. Anyone who is a parent or teacher knows that there will be no shortage of hard work in raising and educating children. If hard is what we want, we're home free: However hard we want parenting and teaching to be, it will be hard enough.

Equality and Competitiveness

As I approach what I take to be the most serious worry about Ritalin, let me mention one other objection that is sometimes raised to it and other programs of medical enhancement. This objection concedes that Ritalin can provide genuine and legitimate advantages for those who use it, but charges that these advantages are not distributed fairly. Responsible diagnoses of attention deficit disorder are expensive and beyond the budget of many families, who are already poorly served by an inadequate health care system. With the

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rise of Ritalin, whose use is concentrated among white, upper-middle-class families, the children of the rich get cognitively richer, and the children of the poor fall ever further behind.

This objection, if it stands on its merits, could be met by efforts to equalize provision of Ritalin (as well as access to medical care generally). If racial or class disparities in Ritalin use were our chief concern, the solution would be obvious. But in my view, the biggest problem with Ritalin lies not with the kids who don't get it, but with (at least some of) those who do.

The real reason that I remain uncomfortable with the rise of Ritalin concerns not the means of enhancement, but the goal itself—what our motives are for seeking enhancement so diligently and desperately, and, even more, what we as a society are currently counting as enhancement. What, in the end, are we trying to gain?

Now, there are clear advantages to being able to pay attention, clear advantages to being able to learn. Dan Brock notes that often our efforts at enhancement are meant to provide us with "intrinsic goods" that we value for their own sake. If these are what we are seeking in putting our children on Ritalin, this doesn't seem particularly troubling. But it seems to me, chiefly as an observer of my own life in one white, upper-middle-class American neighborhood, that many of us

want more than this. We don't want to be better than our own imperfect selves; we want to be better than somebody else. We don't want Garrison Keillor's vision of a world where all the children are above average—we want a world where our own children are more above average than anybody else's. A friend of mine who is a principal in an affluent suburban elementary school says that in his school there are only

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three kinds of children: gifted, very gifted, and extremely gifted. We have grade inflation because so many students and parents insist on getting top grades that now teachers give top grades to almost everybody. And we give our children Ritalin in part because we cannot bear that they be below average; indeed, we cannot bear that they not be above average. This goal itself is troubling to me, independent of any questions about the means to achieve it.

Of course, as Brock observes, such a goal is ultimately self-defeating: Once everyone achieves the same relative enhancement, the competitive benefit of the enhancement disappears. But it may be a long time before we figure this out. And in the meantime we have to live in the world that we have been creating.

The concerns that I am raising now are targeted not only against Ritalin use, but against other, more familiar and widely accepted means of enhancement as well. For I don't think that our non-pharmaceutical strategies to produce better, brighter children are themselves beyond reproach. When I compare my own childhood experiences with those of my children, I feel a sorrow that I think runs deeper than mere nostalgia for a sentimentalized version of one's own past.

When I was a child, competitive sports didn't begin until fairly late in elementary school; now they begin for some children in kindergarten or even preschool. Children who wait until third or fourth grade to join a soccer or basketball team find themselves at an insuperable competitive disadvantage. In fact, in my neighborhood, a number of the children have already burned out on a sport and decided to drop it by the age at which children a generation ago were just beginning. I began piano lessons in third grade; my own children began in kindergarten. How else can they keep up with everyone else's children who have also been studying music from the cradle—indeed, with children who listened to tapes of Mozart in utero?

And so middle-class children have childhoods in which they are chauffeured by their ever-more-frantic

parents from one enrichment activity to another: two sports, two musical instruments, Scouts, Odyssey of the Mind, after-school language programs, science discovery programs, theater workshops. Parents who have a different vision of what childhood might be are reluctant to pursue it, for fear that their children will be left too far behind. One parenting magazine recently published an article about a family that actually chose not to participate in any after-school activities, where this was considered sufficiently unusual to merit a feature article in a national magazine.

The irony in all this is that Ritalin is prescribed for attention deficit disorder. Yet as we struggle to enhance our children faster than our neighbors manage to enhance theirs, we fill our lives with an even greater level of distractions. Diller speculates that if Huck Finn and Tom Sawyer walked out of Twain's pages and into a suburban American school today, they might well find themselves on Ritalin. He worries about our inability to tolerate and appreciate a range of temperaments and personality styles. I worry about this, too, but more about whether we are losing the ability to let children be children—or at least to let them be average

children, not gifted, very gifted, or extremely gifted, savoring childhood as it slips by all too quickly.

If we want our kids to pay attention, maybe we have to begin paying attention to what it is that's worth paying attention to.

—Claudia Mills

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Public Deliberation and Scientific Expertise

The relationship between experts and the public seems to have changed in the past few decades, especially in the area of science. It is not easy, however, to generalize about the nature and direction of this change. On the one hand, as scientific knowledge becomes increasingly sophisticated and specialized, the public's reliance on experts appears to grow, since most individuals are unable to assess scientific claims for themselves. On the other hand, there are many contexts in which the public seems *less* inclined than formerly to defer to expert judgments.

This essay is concerned primarily with the role of expertise in public deliberation about health and biomedical research issues—and, conversely, with the public's role in deliberations that at one time might have been restricted to experts alone. At the same time, I am interested in the character of various voluntary associations that mediate between experts and the public. A great many associations of this kind have been formed in this century—from professional orga-

nizations, such as the American Association for the Advancement of Science, to health charities, such as the American Lung Association or the March of Dimes, to various self-help and activist groups that have only emerged within the last ten or twenty years. In any effort to understand the relation between experts and the public, it is important to examine the social function of these associations and their attitudes towards expertise.

I will begin, however, by speaking more generally about how the contribution of experts to public deliberation about medical or scientific issues has typically been understood.

Outsiders and Insiders

In the literature on expertise and deliberation, two conceptions of the experts' role are dominant. The first conception describes experts acting in what we might call a "technocratic" or "outsider" mode. Here, science