

## Editorial

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# Medicating for a mirage \*

Practical medicine has only slowly come to grips with the problem of defining and recognizing normality. Where bodily structure and function are concerned it has long been accepted that some variety adds spice to life; as the old song goes – “Bless ‘em all, the long and the short and the tall . . .”. Within limits, that is; we have learnt to treat dwarfism when it goes beyond a socially acceptable point; we have developed some idea where body mass index reaches the stage at which health may be menaced; and we seem to recognize broadly a normal range of blood pressure, resisting as a rule attempts to cajole us into prescribing away every whisper of hypertension or that pharmaceutical fiction known as hypotension.

Where psychology and psychiatry are concerned, however, the limits of normality have proved a great deal more controversial, perhaps because absolute normality is so comfortable, though not strictly necessary. A very large number of people have become accustomed to providing themselves pharmacologically with the number of hours of sleep which they believe they need; a generation earlier, a third of the population was busy cocooning itself against reactive anxiety with benzodiazepines; and as Charles Medawar recently discussed in this Journal the same mentality is now causing a great many people to medicate away plain unhappiness [2]. We have still not even managed to straighten out, after thirty years of debate, the question as to how far we should seek to suppress psychotic traits, at the cost of confining many patients unnecessarily to a pharmacological straitjacket.

These things are serious enough where adults are concerned; they are much more worrisome where a strong trend emerges to subject a proportion of a great nation’s normal children to psychotropic medication. It has happened before; in the nineteenth century nursemaids had instructions to put babies to sleep with Tincture of Opium so as to ensure domestic peace; but should we not have learnt better in a hundred years? The current trend – and in North America it has now been gallivanting alarmingly along for thirty years and more – is to take stimulant drugs and use them on a massive scale to treat children for “Attention Deficit-Hyperactivity Disorder” (sometimes simply known as ADHD or ADD) – a foolish mirage of a disease if ever there was one.

ADHD is, according to those who might be expected to know, a behavioural state (or illness?) primarily encountered among schoolgoing children, and characterized by hyperactivity, impulsive behaviour and inattention. Wait a minute; let us turn that sentence around. “ADHD is a label applied by American doctors to children who are very active, impulsive, and do not readily pay attention at school.” How many of the children in your circle, or in ours, or any other, could be said to fit that description? A fifth or a third, maybe? Children like that can and do make some particular demands on both parents and teachers, but so, after all, do children who are merely playful, or who daydream, or who prefer television to homework. So who decided that excitable little children are ill and need to be drugged for years on end – at least in North America?

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\*Much of the material on which this Editorial is based was derived from P.R. Breggin, *Talking Back to Ritalin* [1]. The volume is highly recommended to every reader of this *Journal*.

The answer is partly old, partly complex. The notion that energetic children are ill children who need strong medication was being propagated in the United States as early as 1973 by people like Paul Wendel [3]. Wendel knew exactly the kind of child involved, for he had one in mind:

“... (after) an active and restless infancy, the child stood and walked at an early age, and then, like an infant King Kong, burst the bars of his crib and marched forth to destroy the house. He was always on the go, always into everything, always touching (and hence, usually by mistake, breaking) every object in sight... The mother usually felt – with good cause – that to take her eyes off him for one moment was to invite disaster...” [3, p. 9].

Such an encounter with a life-size Dennis the Menace may have seeded the notion of ADHD, but within a very short period the concept became much wider. In due course the ADHD state was even being diagnosed in children who had no greater sins than that they “wanted to run things”, were “shy”, that their feelings were “easily hurt”, or that they were “childish”, “basically unhappy”, tended to fidget, or were pushed around by other children;<sup>1</sup> by 1995 the label was being attached to children who had “an attentional bias towards novelty and stimulation... whether they find the new stimuli through daydreaming or physical activity” [4]. Despite findings that ratings of ADHD, e.g., during supposed treatment, are not reliable [5], the fundamental notion that ADHD is a pathological entity, albeit with a range of variation in its symptoms, has persisted. It has survived ostracism and scepticism in most of the non-North American literature, and it has been blessed with a detailed entry in that Bible of American Psychiatric Diagnosis, the Diagnostic and Statistic Manual of Mental Disorders [6].

If the label alone was bad enough, the treatment proposed and introduced from the nineteen sixties onwards was a great deal worse. In retrospect it was odd that stimulants should have been regarded as the drugs of choice for a condition of hyperactivity, but stimulants they were. Most notable among them was methylphenidate (Ritalin<sup>®</sup>), and alongside it the amphetamines to which it was very closely similar in its effects. Stimulants are, to put it mildly, not pleasant drugs. They have a very small legitimate field of application and they are very properly subject to strict international control because of the risk of dependence which they bring with them. Their stimulant effects on the cardiovascular and central nervous systems are unpleasant and potentially dangerous, and their effect in depressing appetite is a worrying one in growing children. Oddly, too, they are capable of inducing most of the effects which, in supposed cases of ADHD, they are expected to relieve, including anxiety, agitation, restlessness, insomnia, an inability to concentrate and personality changes. Yet, perhaps because familiarity breeds contempt, North American practice has seized upon these drugs avidly to treat children exhibiting behaviour which their parents and teachers find inconvenient. As the International Narcotics Control Board noted with much concern in 1995: “10–12% of all boys between the ages 6 and 14 in the United States have been diagnosed as having ADD and are being treated with methylphenidate” [7]. The same body recorded a global rise in the production of methylphenidate from less than three tons in 1990 to more than 10 tons in 1995, with the increase still continuing, and with the United States accounting for more than 90% of global consumption, Canada being in second place [8]. Finally, the I.N.C.B. has produced some heart-rending evidence of the consequences of this situation; to cite one point alone, the widespread availability of methylphenidate in American homes has led to a massive rise in its abuse, especially by teenagers [7] and there were corresponding increases in theft of the drug and in emergency-room admissions associated with its use (*ibid*).

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<sup>1</sup>Terms from the *Revised Connors Questionnaire*; and the *Connors Abbreviated Teacher Questionnaire*, both as cited by Breggin [1].

As we pointed out above, the reasons for emergence of this astonishing situation in North America are not entirely simple. It is as if a complex comprising psychiatrists, parents and teachers has rushed headlong into the mess, with each supporting the other. However, where drugs are concerned any non-American observer of the US psychiatric scene soon finds himself questioning the heavy dependence of American psychiatric practice on the pharmaceutical industry. In more than one situation, advisory bodies serving the National Institutes of Health or the Federal Food and Drug Administration have proved to be loaded with psychiatrists having direct links to drug companies. In the case of ADHD the commercial link goes directly into the home; the influential parent-based organization known as “Children and Adults with Attention Deficit Disorder” appears to obtain a very high proportion of its income from drug companies and many of its activities are underwritten by Ciba-Geigy, the producer of methylphenidate [1, pp. 233–234; 9]. And as of 1997, Ciba-Geigy’s new parent company Novartis was proclaiming on the Internet that ADHD was a “neurobiological disability” and that to treat it Novartis had “developed a drug that appears to correct a deficiency of certain chemicals in the brain”.<sup>2</sup> Developed? The drug was synthesized fifty years before Novartis was born and was marketed in 1955. Deficiency? Disability? Where did that come from? One would like to think that a new chemical corporation, loudly trumpeting its worldwide devotion to high ideals, was capable of something better than this.

Above all, however, one needs to consider the situation which arises when, in one particular part of the world, medicine simply goes off the rails. No doubt there are plenty of people in North America who genuinely believe that the rest of the world is out of step, but there is pathetically little to underscore that belief. The notion that one can and should seek to medicate a substantial proportion of a nation’s children into a supposed state of normality is a flabbergasting; it is also reckless one, and as a generation of Ritalinized children grows up we shall surely come to recognize how dangerous it is.

## References

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- [8] International Narcotics Control Board, *Report for 1996*, United Nations Publications, Nr. E.97.XI.3, 1996.
- [9] Drug Enforcement Administration (DEA), Response to CH.A.D.D. petition concerning Ritalin; also covering letter by S.H. Greene, Washington, DC, US Department of Justice, 1995.

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<sup>2</sup>Web-site statement cited by Breggin [1].