Two Cheers for Ritalin

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Attention-deficit/hyperactivity disorder (ADHD) is a well-known disorder that is not known well.

Dr. Sroufe's recent article "Ritalin Gone Wrong," (New York Times, 1/29/12) stands in a long line of CNN-ical media attacks on the safety and efficacy of medication to treat ADHD. His article takes a well known disorder and ignores what has gone right with Ritalin.

The following, for example, is an exceptionally intelligent 40 year old female describing growing up undiagnosed with this well- known disorder:

...Growing up I came by a reputation (honestly earned) of being very forgetful and not finishing things...I seemed to be an extreme case, by all accounts from friends and family...As a teenager I had a difficult time with the repetitive, routine jobs in my family’s bakery...I have always tended to be disorganized and messy...I have found I function best in jobs that I can move around a lot...I find I need an externally imposed structure to my days. It is difficult for me to prioritize and organize myself when faced with an ‘open’ day...Socially, I have a tendency to interrupt others during conversations, small talk can be hard because my mind starts to drift...I tend to lose things quite a bit...I think I am rather ‘stimulus bound’ - that is, I get distracted by things that are happening at the moment and drift towards the distraction, forgetting the task I was originally doing...In this sense, I am impulsive and reactive...Mood swings can be a problem for me...Some months they seem related to PMS, but those symptoms tend to lessen the more I exercise...luckily, I’ve also got a light side that somehow pulls me through...

The plural of clinical vignette is not data, but what is not known well about ADHD is the wealth of scientific data on the clinical description, epidemiology, developmental course, prognosis, etiology, evaluation, differential diagnosis, and treatment for ADHD --- accumulated over more than fifty years of peer-reviewed research that informs clinical practice:

(1) The psychostimulants methylphenidate (Ritalin) and amphetamine (Adderall) are the oldest and most established pharmacological agents in child psychiatry. The beneficial effects of stimulant medication for ADHD have been extensively studied over many years (e.g. Jadad et al., 1999; Swanson, 1993; American Academy of Child and Adolescent Psychiatry, 2007; Greenhill, 2002; Spencer et al., 2006; Wilens et al., 2006). Medications are underused in some areas and may be prescribed too freely in others, not using proper evaluation and follow-up. These medications work for the vast majority of people who are properly diagnosed.

(2) There are some excellent long-term studies about the effects of medication for ADHD (e.g. Weiss and Hechtman, 2003; Mannuzza et al, 1998; Barkley et al., 2006).

(3) There is strong evidence that ADHD is a genetic disorder (e.g Sprich et al., 2000).

If you type ADHD into the Google search engine, the prestigious National Institute of Mental Health web site pops up, linking you to a 46 page pamphlet on ADHD -- a disorder affecting 3 - 5 percent of youngsters under age 18 years characterized by chronic (since childhood) and pervasive (across settings) problems with hyperactivity (trouble doing nothing), impulsivity (trouble putting the "brakes" on emotions and actions) and/or inattentiveness (trouble filtering out external distractions)-- a neurophysiological disorder that doctors have known about and successfully treated for decades.

Physicians cannot persuade their patients to take the required eight days of antibiotics to treat their infections. Yet, some professionals and citizens claim that physicians are convincing parents to drug their children with Ritalin everyday with the help of harried teachers and lazy, self-preoccupied, permissive parents. .Others claim that ADHD is nothing but another myth of mental illness.

My experience - over 35 years - is that most parents never want their child to take medication for any psychiatric disorder.

Some hesitation about prescribing Ritalin for ADHD - and medicines for other psychological disturbances stems from contemplating the complexity of our brains:

In considering the brain, we are talking about a population of hundreds of billions of cells that far exceeds the number of stars in the sky. The number of possible connections these cells can make exceeds the numbers of particles in the universe. To give a sense of this, consider that the cortex of your brain has 30 billion neurons. It has a million billion connections, at least. If you counted one connection per second, you would not finish counting until 32 million years later. (Edelman, 2004).

No doubt scientists have made huge gains in our knowledge about the workings of the brain and the mind. But we do not know how the brain produces the mind --- how consciousness flows from brain tissue.

To circumvent this brain-mind gap in our knowledge and to clarify our diagnostic thinking about the multiple causal pathways of such disorders as ADHD, we benefit from considering the following four etiological families of psychological disorders (McHugh and Slavney, 1998; Kagan, 2010):

(1) brain disease (e.g. autism, dementia, schizophrenia, delirium).

(2) temperamental biases for anxiety and depression (e.g. phobias, PTSD, panic disorder, obsessive-compulsive-disorder, depression).

(3) temperamental biases that make it difficult to regulate impulsive behavior (e.g. ADHD, conduct disorder).

(4) distressful life encounters (e.g. grief, adjustment disorders, trauma).

Not all twisted thoughts are caused by twisted neurons. We live in a time when our excitement with the remarkable technology of brain imaging and advances in understanding brain biochemistry lead to promoting pills for complex problems. Some brain scientists call this obsession with brain based explanations - neuromania (Tallis, 2011).

For those who may remember, we have lived through decades of environmental mania - when experts on the human mind told us that autism and schizophrenia were created by refrigerator mothers who just happened to defrost enough to produce a child (e.g. Kanner, 1943).

We must focus on the individual circumstances and social contexts of patients whose problems result from unique combinations of these multiple etiologies. For example, a youngster with ADHD can be depressed, have an anxiety disorder, live in a family that frequently moves, and have an alcoholic, violent father.

With this ADHD youngster, psychiatric medications sometimes offer life-enhancing measures to improve a youngster’s faulty "hard drive" - improving mood stability, ability to filter out external distractions, reducing anxiety and bolstering self-control. Medication is rarely enough to insure effective treatment. Psychological therapies are required.

Understanding family relationships and individual psychodynamics - and prescribing pharmacotherapy are not incompatible, but often complimentary methods of treatment.

Psychological therapies do much to repair "software," providing supportive settings to promote hope, reroute faulty emotional learning and beliefs, enhance family and peer relationships, and help the youngster enjoy life more. Psychological therapies for ADHD frequently make creative use of principles of behavioral psychology (e.g. Pelham et al., 1998).

Until we have a medical test for ADHD, no amount of anecdotes, scientific data, or testimonials from patients, will convince some professionals and citizens that ADHD is not a myth, but a well researched psychological disorder that can be accurately diagnosed and effectively treated.

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