

Why Ritalin Rules

Methylphenidate is perhaps the most widely misunderstood drug in America today.

By Mary Eberstadt

Let's put the question bluntly: How has it come to pass that in *fin-de-siècle* America, where every child from preschool onward can recite the 'anti-drug' catechism by heart, millions of middle- and upper-middle class children are being legally drugged with a substance so similar to cocaine that it takes a chemist to tell the difference?

The first thing that has made the Ritalin explosion possible is that methylphenidate, to use the generic term, is perhaps the most widely misunderstood drug in America today. What most people believe about this drug is the same erroneous characterization that appeared in the *New York Times*: "a mild stimulant of the central nervous system that, for reasons not fully understood, often helps children who are chronically distractible, impulsive and hyperactive settle down and concentrate."

In fact, the reasons why Ritalin does what it does to children are well understood. According to a government background paper on the drug, it is "a central nervous system stimulant and shares many of the pharmacological effects of amphetamine, methamphetamine, and cocaine." Further, "it produces behavioural, psychological, subjective, and reinforcing effects similar to those of d-amphetamine, including increases in rating of euphoria, drug liking and activity, and decreases in sedation."

Ritalin works on children in the same way that related stimulants work on adults, sharpening the short-term attention span when the drug kicks in and producing equally predictable valleys ('coming down' in street parlance, 'rebounding' in Ritalinese) when the effect wears off. Children are subject to the same adverse effects as adults imbibing such drugs, with the two most common — appetite suppression and insomnia — being of particular concern.

Just as the adult and child physiologies respond in the same way to such drugs, so too do the physiologies of *all* people, regardless of whether they are diagnosed with ADD. As Lawrence Diller puts it in *Running on Ritalin*, methylphenidate "potentially improves the performance of anyone — child or not, ADD-diagnosed or not."

Another myth about methylphenidate is that it, alone among drugs of its kind, is immune to being abused. To the contrary — abuse statistics have flourished alongside the boom in Ritalin prescription-writing.

Though it is quite true that elementary schoolchildren are unlikely to ingest extra doses of the drug, which is presumably kept away from little hands, a very different pattern has emerged among teenagers.

Richard DeGrandpré reports in *Ritalin Nation* that in 1991 "children between the ages of 10 and 14 years old were involved in only about 25 emergency room visits connected with Ritalin abuse. In 1995, just four years later, that number had climbed to more than 400 visits, which for this group was about the same number of visits as for cocaine."

In *Running on Ritalin*, Lawrence Diller reports one particularly hazardous fact about Ritalin abuse, namely that teenagers, especially, do not consider the drug to be anywhere near as dangerous as heroin or cocaine. To the contrary, "they think that since their younger brother takes it under a doctor's prescription, it must be safe."

In short, methylphenidate looks like an amphetamine, acts like an amphetamine, and is abused like an amphetamine. Those who value its medicinal effects tend to explain the drug differently. To some, Ritalin is to children what Prozac and other psychotropic 'mood-heightening' drugs are to adults — a short-term fix for enhancing

personality and performance. But the analogy is misleading. Prozac and its sisters are not stimulants with stimulant side effects, nor is there a black market for Prozac.

Even more peculiar is the analogy favoured by the advocates in CHADD (Children and Adults with Attention Deficit Disorder) that "Just as a pair of glasses help the near-sighted person focus, so can medication help the person with ADD see the world more clearly." But there is no black market for eyeglasses either — nor loss of appetite, insomnia, dysphoria, and toxic psychosis.

Thomas Armstrong, writing in *The Myth of the ADD Child*, probably summarized the drug's appeal best. "Many middle- and upper-middle class parents see Ritalin and related drugs almost as 'cognitive steroids' that can be used to help their kids focus on their schoolwork better than the next kid."

Put that way, the attraction to Ritalin makes considerable sense. In some ways, one can argue, that after-lunch hit of low-dose methylphenidate is much like the big cup from Starbucks that millions of adults swig to get them through the day — but only in some ways.

There is no dramatic upswing in hospital emergency room visits and pharmacy break-ins due to caffeine abuse; the brain being jolted awake in one case is that of an adult and in the other that of a developing child; and, of course, the substance doing the jolting on all those children is not legally available and ubiquitous caffeine, but a substance that the government insists on calling a Schedule II drug, meaning that it is subject to the same controls, and for the same reasons of abuse potential, as related stimulants and other powerful drugs like morphine.

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