

## Does My Child Need Ritalin?

**Stimulants are still the most effective treatment for AD/HD.  
The challenge is to use them wisely.**

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As a pediatrician specializing in attention-deficit hyperactivity disorder (AD/HD), I sometimes envy my colleagues. When they recognize a child's asthma or an ear infection, they're seldom asked to justify the diagnosis or defend the use of established treatments. But parents are understandably squeamish about AD/HD. Followers of the news know that more and more kids are being treated with Ritalin and other stimulants, and that treatment rates vary widely from one community to the next. Many conclude that we're simply drugging healthy children into submission. When I present parents with a diagnosis of AD/HD they often ask, "Why can't boys just be boys?" And when I discuss stimulant therapy they ask, "Won't that speed him up?" or "Won't that make him a zombie?"

The truth is, AD/HD is not an imaginary disorder.

It places kids at risk of everything from school failure to drug abuse and studies have repeatedly found that stimulants are the single most effective way to treat it.

Yes, the erratic rise in treatment rates is disconcerting. But studies suggest that over-diagnosis is not common. In fact, only a small percentage of children with AD/HD are receiving medication at any given time. The issue is not whether children can benefit from these drugs. The real issue, especially for a worried parent, is how to use them effectively.

The first challenge is to get a good diagnosis. It's normal for kids to become restless and inattentive at one time or another; AD/HD should be considered only if these symptoms significantly interfere with functioning. DSM-IV, the accepted guide to psychiatric disorders, defines AD/HD broadly as inattention, impulsivity or hyperactivity that causes significant trouble at home and school. The DSM doesn't offer precise, numerical measures of these problems, but it does provide criteria for making a diagnosis. Besides assessing the child's behavior, academic standing and social functioning, a physician who suspects a child has AD/HD should seek out independent assessments from teachers and parents. Their responses to questionnaires can help gauge how much difficulty the child is having compared with his or her peers.

AD/HD is not the only thing that keeps kids from concentrating. Hyperactivity or distractibility can also reflect social, emotional or developmental problems that exist apart from or in addition to AD/HD. I once had a 9-year-old patient whose teachers considered him inattentive because he misunderstood directions and often asked them to repeat questions. It turned out that his hearing was mildly impaired, and more specialized tests showed he was unable to process auditory information normally.

If a child does have AD/HD, medication is not the whole secret to managing it. Parents and teachers can help kids cope with the condition by establishing consistent routines, reinforcing appropriate behavior and making educational accommodations. Treatment of preschoolers should start with these behavioral interventions, and move on to medication only as a last resort.

School-age children are a different story. Stimulants such as Ritalin (methylphenidate), Dexedrine and Adderall are highly effective for kids in this group, and parents shouldn't feel guilty about employing them along with behavioral and educational interventions. None of these drugs will cure AD/HD. But when they're effective, they can improve attention, reduce restlessness and foster better relations with peers, parents and teachers. Each of the three stimulant medications has roughly a 75 percent response rate and kids who don't respond well to one will often respond to another. Overall, an estimated 90 percent of school-aged children with AD/HD respond well to treatment with these drugs.

All stimulants have mild, dose-related side effects, such as decreased appetite at lunch and a modest delay in bedtime. Some children become moody or irritable as the medication wears off at the end of the day, and a few report headaches or stomachaches. Studies indicate that some children may grow more slowly during treatment, but no one has documented any effect on kids' ultimate height. A careful physician can minimize all these side effects by "starting low and going slow." I usually start a child at half the dose I expect will be needed, then raise it gradually to find the lowest effective dose. And, I generally try all reasonable doses of one medication before switching to another.

Some critics worry that kids who respond well to stimulants in the short-term may suffer adverse effects later. But Ritalin and other amphetamines have been available for more than 40 years and been given to millions of children. Few other medications can make this claim, and certainly no other medications have been scrutinized and researched as extensively. Long-term follow-up studies to date are limited but quite reassuring. For example, some parents worry that treatment with stimulants will encourage their kids to use illicit drugs later. The reverse is true. Although youngsters with AD/HD are indeed at increased risk for drug abuse, those treated with stimulants appear less likely to develop that problem. So, think twice before you rule out stimulants. You may be depriving your child of truly effective treatment. A

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