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Raising the Ritalin Generation

By BRONWEN HRUSKA

I REMEMBER the moment my son's teacher told us, "Just a little medication could really turn things around for Will." We stared at her as if she were speaking Greek.

"Are you talking about Ritalin?" my husband asked.

Will was in third grade, and his school wanted him to settle down in order to focus on math worksheets and geography lessons and social studies. The children were expected to line up quietly and "transition" between classes without goofing around. This posed a challenge — hence the medication.

"We've seen it work wonders," his teacher said. "Will's teachers are reprimanding him. If his behavior improves, his teachers will start to praise him. He'll feel better about himself and about school as a whole."

Will did not bounce off walls. He wasn't particularly antsy. He didn't exhibit any behaviors I'd associated with attention deficit or hyperactivity. He was an 8-year-old boy with normal 8-year-old boy energy — at least that's what I'd deduced from scrutinizing his friends.

"He doesn't have attention deficit," I said. "We're not going to medicate him."

The teacher looked horrified. "We would never suggest you do that," she said, despite doing just that in her previous breath. "We aren't even allowed by law to suggest that. Just get him evaluated."

And so it began.

Like the teachers, we didn't want Will to "fall through the cracks." But what I've found is that once you start looking for a problem, someone's going to find one, and attention deficit has become the go-to diagnosis, increasing by an average of 5.5 percent a year between 2003 and 2007, according to the Centers for Disease Control and Prevention. As of 2010, according to the National Health Interview Survey, 8.4 percent, or 5.2 million children,

between the ages of 3 and 17 had been given diagnoses of attention deficit hyperactivity disorder.

What I didn't know at the time is that there's no clinical test for it: doctors make diagnoses based on subjective impressions from a series of interviews and questionnaires. Now, in retrospect, I understand why the statistics are so high.

We made an appointment with a psychiatrist on the Upper East Side of Manhattan. After we filled out an extensive questionnaire, she did the interviews and had Will's teachers fill out short behavior questionnaires, called Conners rating scales, which assess things like "squirminess" on a scale of one to five. In many cases, I discovered, diagnoses hinge on the teachers' responses.

A few weeks later we heard back. Will had been given a diagnosis of inattentive-type A.D.H.D. It was explained to us this way: Some children who are otherwise focused (Will had been engaged during his interview), have a hard time focusing in "distracting situations" — in Will's case, school. The doctor prescribed methylphenidate, a generic form of Ritalin. It was not to be taken at home, or on weekends, or vacations. He didn't need to be medicated for regular life.

It struck us as strange, wrong, to dose our son for school. All the literature insisted that Ritalin and drugs like it had been proved "safe." Later, I learned that the formidable list of possible side effects included difficulty sleeping, dizziness, vomiting, loss of appetite, diarrhea, headache, numbness, irregular heartbeat, difficulty breathing, fever, hives, seizures, agitation, motor or verbal tics and depression. It can slow a child's growth or weight gain. Most disturbing, it can cause sudden death, especially in children with heart defects or serious heart problems.

I consulted our longtime pediatrician, who told me that if Will had A.D.H.D., medication was the only way to give him real relief. I also read through hundreds of online posts, though I stopped after a diatribe about a nation poisoning children's developing brains.

Meanwhile, Will was sitting out of music class on a regular basis. In addition to hating the recorder, he'd discovered he could get a cute girl to laugh by making funny faces. We decided to trust the doctors and the school. If Will really had A.D.H.D., we should treat it.

Starting in fourth grade, he took his medicine every morning, and he went to the school nurse after lunch for another pill. The doctor raised the dosage until the teachers saw results.

One afternoon, Will told me that during reading period he forgot to talk to his friends. “Everything got really quiet,” he explained. “It was like I was inside the book.” It was what his teachers had wanted. What we’d wanted. For the medication to focus him.

I should have been elated that the problem was so simple to fix. But I wasn’t. I couldn’t help wondering why forgetting to talk to his friends was a good thing and why we were drugging him to become a good student.

At home, he didn’t seem different, just hungry, since he now ate almost nothing at school. When I did some research, I learned that methylphenidate is also prescribed as an appetite suppressant.

The next year, in fifth grade, the pills stopped working. The doctor upped the dosage a few more times, then switched medications twice, but nothing. I thought back to Will’s fourth grade teacher, who had liked him. Then I thought about his current teacher; some of the other parents had complained that she didn’t seem to know what to do with boys at all. Maybe Will’s successful fourth grade year had had less to do with the medication than we’d all believed.

Sometime toward the middle of fifth grade, he simply refused to take the pills. He’d seen a television show about a girl whose parents kicked her out of the house for crushing and snorting her Adderall, and that convinced him that his medication was too dangerous.

THAT was five years ago. Will is about to start his sophomore year of high school. He’s 6 feet 3 inches tall, he’s on the honor roll and he loves school. For him, it was a matter of growing up, settling down and learning how to get organized. Kids learn to speak, lose baby teeth and hit puberty at a variety of ages. We might remind ourselves that the ability to settle into being a focused student is simply a developmental milestone; there’s no magical age at which this happens.

Which brings me to the idea of “normal.” The Merriam-Webster definition, which reads in part “of, relating to, or characterized by average intelligence or development,” includes a newly dirty word in educational circles. If normal means “average,” then schools want no part of it. Exceptional and extraordinary, which are actually antonyms of normal, are what many schools expect from a typical student.

If “accelerated” has become the new normal, there’s no choice but to diagnose the kids developing at a normal rate with a disorder. Instead of leveling the playing field for kids who really do suffer from a deficit, we’re ratcheting up the level of competition with

performance-enhancing drugs. We’re juicing our kids for school.

We’re also ensuring that down the road, when faced with other challenges that high school, college and adult life are sure to bring, our children will use the coping skills we’ve taught them. They’ll reach for a pill.

Bronwen Hruska is the author of the forthcoming novel “Accelerated.”