ADHD and stimulant drug treatment: what can the children teach us?

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Alexandre Erler, Guest Editor

The concise argument

The treatment of children diagnosed with attention deficit/hyperactivity disorder (ADHD) with stimulant drugs has been a subject of controversy for many years, both within and outside bioethics, and the controversy is still very much alive. In her feature article (see page 359, Editor’s choice), Ilina Singh, a major contributor to that debate in recent years, brings fresh empirical evidence to bear on it. She uses new data to deal with two key ethical concerns that have been raised about the practice. First, does medicating children with ADHD compromise their capacity for autonomous moral agency? And second, does it pose a threat to their authenticity? Singh neverthel...
how valuable authenticity (in the self-discovery sense) might be, it is not clear that it must always trump other considerations, including the prudential interest of the child in completing compulsory education. The question of authenticity in this sense is complicated by the possibility, alluded to by Singh, that by suppressing one aspect of the child’s authentic self, the medication might nevertheless allow another one (say, a taste for some particular academic subject), which had been overshadowed by the previous one, to finally be expressed—an interesting thought which deserves further consideration and discussion.

Concerns about authenticity in the self-creation sense, which can also be expressed in terms of concerns about autonomy, are raised by Steven Rose (see page 371). Although the children interviewed by Singh do report valuing the increased capacity to meet social expectations that stimulants provide, this is not enough to quiet the above concerns, as theorists of autonomy usually place further constraints on the sort of evaluative attitudes that can count as autonomous (eg, that they would survive a process of critical reflection), making autonomy difficult to assess in cases such as those discussed here. Rose also calls into question the conclusions drawn by Singh from these interviews, suggesting that the children might merely be repeating what they were told by their parents and educators, with their discourse concealing the fact that the symptoms for which they are being treated might represent a legitimate response to oppressive circumstances and expectations. I will let readers assess the persuasiveness of Rose’s critique for themselves, yet would like to raise the following general question in response: If we cannot trust the children’s reports because they can only parrot the views of their parents and teachers, and if we cannot listen to parents and teachers because of their tendency to misdescribe the situation in accordance with their own prejudices, whose observations (as opposed to mere speculations) are we to rely on to develop an accurate picture? Radically critical views of stimulant drug treatment seem to rest chiefly, as Singh suggests in her response (see page 372), on general a priori claims about children with ADHD. Proponents of such views typically do not provide any concrete evidence demonstrating that these children’s personal circumstances can be adequately described as oppressive, or that environmental interventions (say, a different learning structure), unsupplemented by medication, would allow them—all of them, or at least the vast majority of them—to function successfully. It seems to me that this places such views on shaky ground.

The ethical debate on the pharmacological treatment of children diagnosed with ADHD will, and needs to, continue. Several concerns, such as that of misdiagnosis, still need to be tackled more effectively. However, I believe that Singh’s latest contribution, and the responses to it, together make a strong case for the value of an empirically grounded approach, and the need to move towards more nuanced views which recognise both the benefits and potential ethical pitfalls of stimulant drug treatment for ADHD in children—rather than unqualitiedly embracing or condemning the practice.

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