INTERVIEW DR. PETER JENSEN

Formerly the head of child psychiatry at the National Institute of Mental Health, **Jensen** was the principal author of the landmark NIMH study, the Multimodal Treatment Study of Children with Attention Deficit Hyperactivity Disorder (MTA). He is now the director of Columbia University's Center for the Advancement of Children's Mental Health.

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There doesn't seem to be a lot of consensus about ADHD, even among your own peers. I've have heard so many different things over the last few months that I'm starting to look like a frazzled parent who doesn't quite know the truth. Do you think there's consensus out there?

I think there's consensus among most medical professionals that ADHD is a neurobehavioral disorder, that it's severe, that it affects boys somewhat probably more than girls, and that it's treatable. Now, where consensus begins to break down is how workable the treatments are, and effective and safe over the long-term; and what the exact causes of it are. And it likely has many different causes.

There isn't good consensus about the best way to draw the boundaries between ADHD and other syndromes. But I think you will find that most experts do agree that it's a real disorder that we can characterize reliably, that it has bad outcomes if left on its own, that we can do something about it, and that there is a research agenda that does need further pressing forward and carrying out. . . .

And the simple notion that genes are the cause is not a very satisfactory solution, because genes are involved in everything. We know that genes explain height. . . . We also know that genes were the same 300 years ago, and as a society, we're two to three feet taller than we were back in the Middle Ages, with just mild to moderate differences in our nutrition--same genes, very different outcomes. And so the knee-jerk reaction, to assume it's all in the genes, is really, I think, a little simplistic.

A lot of people would say something like, "My kid is kind of short and I know I can give him growth hormones and he might not get so teased in school." And they say, "My kid has ADHD, but there is a drug that helps." But how is that different? Why give a kid a medication for something like that? Yes, it can improve kids in many ways. But is it warranted?

Well, it depends what we, as a society, think are conditions we want to treat. . . . If someone has schizophrenia, should we intervene, even though we can't point to the exact spot in the brain where there's a problem at this point, although we're likely to in five or ten years? Should we intervene there? Does that suffering count? I think it does. How about the suffering of autism? How about the suffering of ADHD, when it's so severe this child can't sit still at age two and three, and is at risk of running out in front of a car?

Those are maybe the easy cases, and most of us would say, "We have to do something," because these are disturbances of brain function, the organ of the mind. Why should we treat the brain as an organ any different than the kidney or the liver? But how about milder cases? Then we get into the gray areas. When do we decide to intervene at this level of societal suffering? . . .

The job of medical science is to decide when it's a real medical condition that has suffering and impairment and lowers the quality of life--and sometimes not only lowers the quality of life, but lessens productivity and even actual days of life. Depression is a good example; we know there that life is actually shortened by suicide.

But kids with ADHD are also at risk for dying somewhat earlier. They are at risk for accidents. It's true for most of the psychiatric disorders. We don't know all the reasons why that is. Sometimes it's accidents, sometimes it's something like suicide. Sometimes it's because people don't obtain adequate health care. There are a lot of mysteries here.

But the diseases of the mind shouldn't be treated any differently than the diseases of the other parts of the body, and we've done that too much, I think, as a society. . . .

What about the idea that ADHD is not a disease--that it's simply behavior that's a result of ineffective parenting?

"There is a real need to get the message out, to help parents understand ADHD. This is not something a child chooses just to do."

There's no question that a child's behavior affects adults, and adults' behavior affects children. We call that "the human condition." Can it be the case that some children's difficulties are because they're not being handled appropriately? Absolutely true, of course. But does that explain ADHD? Well, all of the studies suggest just the opposite, in fact. When we do these studies to teach parents the most elegant, best parenting strategies that we know how to do--including things you have to get a PhD in parenting to learn--when we give parents and teachers those skills, does it make these problems go away? No. It reduces them a little bit, but there's something different for many of these children. . . .

There is a real need to get the message out, to help parents understand ADHD. This is not something a child chooses just to do. "Oh, I think I'm going to have real difficulties attending," or, "I don't want to attend," or "I want to look out the window and not attend to the blackboard." If you study these kids as we have, these kids feel bad about themselves. They don't want to be this way. In many ways, it's like a learning disability. Whereas you can maybe sit and listen and attend to me for hours on end, these kids' minds are off after 10 or 15 or 20 seconds. . . . Most kids can track this kind of situation, or a classroom situation, for minutes, tens of minutes, twenties of minutes, or even an hour on task, with minor deviations. . . . These kids can't. It's not that they're willfully disobedient or that we have bad teachers. . .

And yet, for probably hundreds of years, there have been people with this disorder. And they have lived and survived, I assume, without medication.

We've had diabetes for hundreds of years, and we've had hypertension for hundreds of years, and we've had asthma for hundreds of years. . . . We've had cancer. We've had lots of things for hundreds of years. That doesn't necessarily make it a good thing. And when you sit back and you allow yourself to be informed by research . . . our studies show that these kids have bad outcomes when we don't help them.

So, what's our responsibility as a society if a child has a bad outcome for untreated asthma? Should we treat it? Yes. If he has a bad outcome for untreated ADHD and we can do something about it, would it be ethical to withhold treatment or say, "Well, just let parents handle it?" I took a Hippocratic Oath that said that if I could intervene and help in a medically responsible way that was safe and effective, that was my job. And that's my job as a medical scientist, as well.

But yet these drugs help everyone. So why not give them to everyone?

I think we have to think about the balance of risks and benefits. . . . If we gave Ritalin to everyone, would that be a good thing? I'm not so sure it would, because then we'd put more and more medication out there in an area where some people might be prone to abuse it. It's not clear that there's a big benefit. With ADHD children, we have studied them, and we know there's a big benefit when we treat them. . . .

When we study normal people and give them stimulants, there's a little benefit. Is that worth putting a medication on the street and then charging everyone's insurance plan? That's kind of like cosmetic surgery. Should you and I be forced to pay for somebody's nose job? I don't think so. As a society, we've decided some things are cosmetic. Some things are elective surgery. Some things are nice, but not medically necessary. ADHD is a severely impairing condition for the many children that suffer from it. It's thought that treatment is medically necessary, because they're going to have bad health outcomes. . . .

Some people would argue that the medications were actually discovered before the diagnosis was sort of fine-tuned, so therefore the diagnosis was made to fit the medication. What would you say to that?

Some people have suggested that the ADHD diagnosis was invented to fit a drug. This is bizarre. In actual fact, the syndrome was described back as early as the 1900s, and we have other reports going way back. It's true the label has changed, but the classic core symptoms haven't really changed hardly a smidgen. And so when people go back

and they study "the hyperkinetic reaction of childhood" and "minimal brain dysfunction and damage," these are the same children; it's quite clear. . . .

Six thousand studies, and 170 double-blind control studies. Why is there still controversy?

That's a hard question. I think the controversy that currently exists has to do, first and foremost, with stigma. When we see a child misbehaving, we apply our common sense, everyday understanding to things that all of our social instincts tell us. If I see a child scream in the grocery store, my first instinct is to control that child. I don't know what else the parent has done or is doing, or what they've struggled with. . . . I don't have that information. I am wired to respond as a social organism. . . . And so, it's so easy to assume the parent is at fault.

I'm always amused when I see somebody who starts off with that commonsense understanding, and then either has a child with a severe emotional or behavioral disorder, whether it's ADHD or depression, or even autism. Then they finally understand that the brain is an organ also, and it can become ill. . . .

What research has shown us is that, in fact, children have just as much effect on parents' behavior as parents' behavior has on children. . . . Parents are still important, and we need to do all we can to help parents. But the other two-thirds wrong was the complexity of brain development and the importance of genes and how all of these factors come together. And we can do something about it. . . .

The pharmaceutical industry spends a lot of money in an attempt to convince you that that little pill is the next little miracle. How do you feel about that?

The FDA regulates what the drug companies--or anyone, for that matter--can do and what they can advertise if it's a pharmaceutical. The bigger worry that I have is that there are so many things that are totally unregulated. Do you realize that you can advertise for biofeedback or herbs or blue-green algae or a host of other things, including swimming with dolphins, as a cure for autism now? And there's no agency to say, "Not so fast." . . . What the drug companies are doing is guided by science. It's not the only science, but it's guided by science, and it's regulated by the federal government.

. . . Parents hear misinformation around medications or some of the other evidence-based treatments, like the behavior therapies for ADHD. And they're afraid, or misinformed, or alarmed, or pinning their hopes on basically a shooting star. They chase after something that has untold costs, no regulation, no data, and, as a minimum, is costly, and sometimes dangerous.

So do I think it's a good thing that industry is trying to teach doctors about what their science has shown? . . . Absolutely. I'm all for it. We need more of it for science. . . . We need more of it for the behavior therapies. . . . What I've seen in some of the things that are put out by industry, when I and most of my scientific colleagues review them, we specify say that they should put in the role of behavior therapies. We make them do it. We say, "You've got to do it. . . . You can't go there and just educate them about your medication. We want you to educate them about the science and these therapies as part of the science." Do I think that's a good thing? Yes, I do. I think that's a good thing. Should it be regulated? Yes. Someone has to be watching the henhouse.

How has the discovery of these new drugs changed your practice?

I trained in the late 1970s, early 1980. At that point, there was just probably a small handful of studies that had been done in this area, and treatments hadn't been developed--not the behavioral treatments that were well known, well tested and well established. And the medicines hadn't been really developed. Ritalin had been approved right around that period, so some people were using it. So there was evidence there. But practices change slowly. I was trained to believe that all of these things that went on in the child's mind were a function of just thinking and feeling and experiences, and if you were just a good enough parent you could fix anything. . . .

Generations of child psychiatrists were all trained to try to cure the same children through therapy, and trying to be real gentle and nice to the parents and kind of get inside and unpeel the onion and look for the early, critical, bad thing that parent must have said that made this child this way. We know that was all nonsense. But I trained to practice that way. That was what I was doing with the first kids I ever saw. My first teacher kind of said to me, "I hope you're not going to be one of those terrible people that uses medicines with children." In many ways, I had to go through a re-education--except that I had to train myself. . . .

My practice has changed a lot. Nowadays, because of science, because of studies I have been involved in, when I treat an ADHD child, I say to a parent, "Here's what the data show for medicine. Here's what the data show for the behavior therapies. Here are all of these other therapies out there that you've been hearing about that, for which there are no data. . . . Educate yourself.". . . And so I help them to think through the problem. And that's what I have to do ethically and responsibly as a doctor.

And yet perhaps part of the problem is that most of the studies just study the medications, so the data is there for the medication. Perhaps there isn't that much other data because there's not a lot of money out there to study the impact of behavioral therapies?

In actual fact, the money to study the medications has not been any more plentiful than the money to study the behavior therapies. The drug companies have not wanted to study kids and medicines. They're scared of them, because they've been afraid of lawsuits. . . . So 80 percent to 90 percent of the research has all been supported by the federal government. And what the federal government would do is not say, "Oh, we want medication studies." No, they'd say, "We want studies." . . . Two or three years ago, we've gone through and we counted all of the studies in the ADHD area that met certain criteria.

Well, we had about 600 studies--good clinical trials of one form of meds or another. But there were another 1,500 studies of non-meds. The med studies are easy to describe. and they're easy to kind of get the word out on. But in actual fact, most studies are not medication studies. . . . We hear about medications in the news, because it's a bit of a tempest in a teapot. But we have a lot of studies of the other treatments.

What do we know from our studies? We know that medicines work. What do we know from our behavior studies? We know that behavior therapies work. Amazingly, however, there have only been about . . . two dozen studies that compared the two. That was a big gap, because you had all the true believers in medication studying medicine because that's what they did. You had all the true believers in therapy studying the therapies, because that's what they did. And what did both those two camps show? They both showed that their treatments worked. Only rarely did those two camps come together and say, "Let's compare the two. Let's see when we put the two together if we even get additional bang for the buck," so to speak.

When I first came to NIH, that seemed to me a great problem. How was the doctor to decide what was the best treatment? How was the parent to know, unless someone compared them? So we reviewed all of the current studies, and we determined that we really needed a study that brought all the true believers in therapy together, with all the true believers in medicine--the best scientists we could find in the country. Put them into the same study, and do a fair test of the medicine versus these other treatments that work, and the combination, and to see what was going to be the best thing for children over time.

What we found was that they both worked. We knew that all along--that medicines worked, and that behavior therapy worked. But we found that the medicine was more powerful, on average, for most children. Now, the behavior therapy worked very well for some children, and the parents need to know that it works well. But the medicine works well, too, and actually better. Parents needed to know, if they were to flip a coin, what will give them their best chance?. . . And we found that the combination worked maybe even a tiny smidgen better than even just medicine alone. . . .

Let's talk a bit about your enemies. I met one the other day named Peter Breggin, and he called you "public enemy number one."

Well I'm quite amused to hear that I'm "public enemy number one." Actually, Peter Breggin once described me as "the greatest single threat to America's children," on his homepage. . . . It was back at a time when I held a job at NIH as the Associate Director for Children's Research, and Peter Breggin very much wanted to be an invited speaker at a conference. So he approached me. The speakers were all supposed to be actual active scientists--publishing in journals that met the highest standards of peer review and rigor by the larger scientific community.

I had a role in making recommendations of who would speak, of who were scientists of credibility. He spoke to me on the phone, and I said, "Well, you know, Peter, you're not really a scientist--you're a commentator. But the commentator is supposed to be an objective jury, independently picked, that I can't pick. And they should have no vested interest in weighing in, other than being good scientists. You have a clear vested interest, you clearly have an opinion. . . . You're selling books and you're doing other things on based on your own opinion. You have a business here." I said, "So, I don't think so."

Then my name showed up in his web page, and there were three full pages . . . all about "moi." It was a conspiracy theory, basically, that somehow I had withheld my own data and that I had wanted to get a cushy job with the federal government, so I had suppressed the publication of my own findings. It was really quite amazing, the little story that he had put onto the web about me. . . .

Then, apparently, lots of people read his web page. . . . NIH began to get all kinds of calls from people, saying that we should stop the NIH Conference because it was going to be pushing Ritalin or medication. . . . So the decision was that Breggin should be invited . . . and let the objective panel of scientists, who are independent, evaluate his data.

. . .

And you evaluate the data of a lot of scientists. Where does Peter Breggin get his data? It reaches the households of millions of people out there.

When Peter talks, he's a very effective speaker. He speaks with an air of authority and passion and conviction. He's a very good speaker. . . . He takes other studies and reads them, and then writes about them. With my own studies, all I can say is that he takes them out of context and does not present the whole study. He presents pieces and spins it in a way that helps him with his message. . . . It's not a scientific message, from my perspective, and I think it's not from the perspective of most scientists. There are real concerns that it can be very misleading, and even harmful to the general public.

A lot more people, other than Peter Breggin, are behind this. There's the Church of Scientology, which has been very actively opposing psychiatry for quite some time. How has that impacted your field of psychiatry, and why do you believe that they have this agenda?

. . . I was up in Toronto and I was at the America Psychiatric Association Meeting and I noticed on the other side of the street there was this big long line of people picketing. They were from the Scientology group. I didn't know it at the time, but I figured it probably was, because they usually picket all of the meetings. And they were wearing black shirts and carrying around black balloons that all said "Psychiatry Kills."

So I thought, "This is amazing. Here are all these people over here, and here are all of these psychiatrists, who're supposed to be trained in communication." So I thought, "Well I'm going to go over across the street." I paired up with a young man and began to ask him questions like, "How did you kind of get affiliated, and what did you learn, and what do you know about psychiatry--do you think it kills?" I mean, I have been described as a terrible person, but I didn't think I was a killer. . . .

Pretty quickly, he was joined by his supervisor, and then by her supervisor, and pretty soon I was talking to the organizer of the whole march. I began to ask her where she got her information. And she said, "Well, we have this expert neurologist, Fred Baughman." And I said, "Fred? I know Fred! Fred and I have communicated multiple times." He had written me all these letters back at the NIH. He would write these long diatribes, and it was always kind of difficult to figure out who had to respond to Fred, because . . . the letter was full of a lot of issues and questions, and you wanted to do a good job responding.

That job often fell to me, but sometimes to one of my colleagues. And if we didn't respond quickly, Fred would write another letter, saying that the federal government was totally unresponsive to his questions. Fred had a lot of unusual opinions, and he certainly was not a mainstream neurologist, even though he would like to use his name and his credentials and initials. So here this group was, using Fred as their sole source. . . . I said, "You know, you ought to get yourself a real scientific advisory board." . . . But, you know, sometimes the sound bite carries the day. Peter Breggin and the Scientologists have been very effective with the sound bite. They've been good, very good.

So how do you counter that?

Talking to you, I guess, is one thing. One of the ways, I think, to counter it is to put all of the science on the table. . . . If there are areas where the science is defective, it should be exposed as defective. Science is not a cult or a religion. It should be open for public inspection, open for continuous improvement. And anybody who doesn't open their cards that way loses his credentials . . . because now they're practicing personal opinion or religion.

I think the first thing is to have an open, fair, impartial process. That's what NIH does for these Consensus Conferences. . . . We did this careful background check to make

sure that they weren't receiving money from industry and hadn't published papers on ADHD to make their career in that area, and that they were informed scientists and had good scientific credentials in other fields, but also were expert with children. NIH was charged by Congress to set up this objective kind of process in all kinds of areas of science, because there's so much misinformation. . . .

Someone described to me the NIH consensus being a group of 12 scientists that had 6 days to evaluate 6,000 studies. And while they were good scientists, they had never thought about the same things you have to think about every day as a clinician, because they have other fields of interest. Can you respond to that?

If you want to get objective scientists, they can't really be publishing in the area of ADHD. They might be publishing in the area of pediatric developmental disabilities. It's nice to know about children; it's nice to know about what constitutes a good clinical trial. . . . That expertise is needed.

Now, I, and many other scientists like myself, are often called upon to review areas we don't know well. And while we can't review the area as well in terms of the specific disorder, we can refute the quality of the study. We can say, "Is the data emerging from this study based on solid scientific design of a study, on good principles of measurement?"

. . . They didn't have just six days. Actually, they had six weeks, because we gave them the literature well ahead of time, and their job was to review that literature ahead of time and to be informed and read more and more. Now, in those two days, they had to review the testimony that was actually delivered face to face. . . . Scientists are busy, and I can't say how well every scientist reviewed the data. But they were scientists and their reputations were on the line, and so I trust ethical scientists, who are known for their good thinking, to do that. But it's an imperfect process. Could they have missed some things? Oh, absolutely. Could they have underestimated the value of some of the evidence? Absolutely. . . .

To paraphrase what the consensus statement said, in an objective way, it basically said, "Yes, ADHD is a valid diagnosis, but no, we do not know much about many other issues of it." And it seemed to me that it might have harmed ADHD's case.

I've been asked several times to kind of consolidate or collapse what I felt the statement said. Basically, it said that there's some validity for the diagnosis of ADHD as a disorder, and that just to kind of kick it full of holes would be a little bit inappropriate. We don't know exactly whether to call it a very severe behavior problem, a mild behavior problem, or a severe medical disorder. Where do you draw that cut?

. . . The Consensus Conference said, "It appears to be a valid disorder. It can be reliably diagnosed. But we need more work on that." That's what they said. But then they went on to say, "It has bad outcomes, it's severely impairing and it's a major public health problem." And so I was real pleased, because I thought, "You know, as a society, we can't ignore it. We can't just say it's not a public health problem, because it is a public health problem, and it has those severe outcomes for many of these children."

Then it went on to say that the treatments are safe and effective, in the short term. It said the medicines work and the behavior therapy works, and it said that the medicines tend to be more effective than the behavior therapies in short-term trials. But some people were disappointed that it didn't say, ". . . and so everybody should use medicine." They said, "No, we don't want to say that." It was an objective group of scientists. . . . If Peter Breggin had his way, he would have said, "Never use medicine." . . .

It pointed out some important gaps. It said, "We don't know enough about long-term safety, and the federal government should do more." Well, that's a win for parents as far as I'm concerned, because that means that parents have an agenda. . . . They should be asking the federal government to do better long-term studies. . . .

Two other things it said--and I was very pleased about them, because it showed the warts--it said, "The way we're treating these children is a mess. . . . Everybody's not working together, and our system isn't working together very effectively. We need better systems for these children." That wasn't a feel-good message. . . . The other non-feel-good message was for the scientists. The report said, "You guys don't know anything about how to prevent this disorder, and you're not studying it. Start working on prevention." . . .

There are reports that the use of psychotropic medications has increased 700 percent in ten years. And there are other reports that say there's a three-fold increase. What's the truth to that, and what's behind this trend?

Whether it's increased three-fold or five-fold or seven-fold is really not the big point. . . . The story is that it's increased enormously, and that's the question. And the answer to that is, I think, two or three major factors.

The first is that, in the early 1990s, the Department of Education mandated the states, and said, "Many of you have thought that ADHD was a thing you didn't have to worry about. But we've reviewed the evidence and the literature, we've listened to parents, we've listened to the scientists, we've held congressional hearings on this, and we're convinced that this disorder fits under special education law. And you can't say to a parent, 'It's not our problem.' It is your problem. And so, be on notice that that's our position." . . .

At the same time we had, I think, increasing power and passion on the part of parents, who felt like their children had fallen between the cracks, just like with learning disabilities. And those parents were organizing, becoming more eloquent and more effective, and understanding that they really had to kind of get their oar in the water, to speak up, because their children's lives and health was at stake. . . . So schools began to realize they had to do something about it, and it put them on line to use their resources for these children. . . . And so while we don't know this for certain, a lot of the big rise happened right around those years, 1990, 1991, 1992 and 1993.

Now, the other big rise, and the other big factor, I think, that took place during that time, was health care reform. And health care reform bit mental health with a vengeance in many ways. Because what it said to mental health was, "We're cutting way back on the kind of therapies that we're going to offer, and we're going to set total number of sessions. And we're going to say when you can get sessions and why you can get, say, therapy sessions."

So what we hear from many parents was that they could not longer go see a therapist for 50 or 60 sessions a year. For ADHD they would be asked, "Is your child getting medicine?" . . . More and more, doctors were being asked to say, "We can only approve therapy sessions if you've also given a trial of medicine." Or parents were being told, "We can only give therapy if the child is also getting medicine."

How does one explain that the US consumes five times more methylphenidate than any other place in the world?

It's a not a very hard explanation, actually. I and other colleagues were at a meeting set up by the Council of Economic Ministers in the European Union. Their drug enforcement czar and their health czar, or their representatives, came from each country to this meeting. And the reason they came to a meeting was because there were concerns that they were hearing more and more from parents around Europe that their children had ADHD.

We know from international studies that ADHD is pretty much the same across all of the Western world. We're not sure about non-civilized areas, or less-civilized Third World areas. But across Europe, it's pretty much always the same, and parents were feeling that their children were being denied treatments. . . . You go to some countries and they'll say, "Well, you can prescribe Ritalin, but only a child psychiatrist can do it." In the former Eastern bloc, there may be five child psychiatrists in the entire country, and 3,000,000 children. I tell you, that's going to really cut the prescriptions way down.

In another place, they'll say, "You can only prescribe this medicine if it's been approved by three independent professionals." In other places, you can't prescribe it at all. . . . What this Council of Ministers concluded is that ADHD in Europe is probably under-diagnosed and under-treated by 20 to 1. Isn't that amazing?

They don't have legislative force over each of the countries. But this group then made a recommendation that each country should go back and have their health minister and the drug enforcement ministers meet together to find a way to more effectively meet the needs of these children. . . . In some countries, they're using anti-psychotic medicines at terrible rates to treat ADHD children. So, yes, they're not using Ritalin. They're using things that are much less safe, that we know cause tics or permanent kinds of motor problems if used for a long period of time. . . .

. . . These are Schedule II drugs. Do you think that that classification is warranted in this day and age?

I think the Schedule II classification appears to be warranted from the federal perspective, and this was reviewed recently. I know there are varying opinions at various parts of the federal government about this, but we know that the siphoning off for illegal purposes of these medications does happen. It's not a major phenomenon. Cocaine, for example, is the big substance of abuse in terms of the speed kinds of agents, and illegally prepared speed agents are much more common.

. . . If you wanted statistics, it's about one out of every 5,000 Ritalin tablets . . . ends up getting hijacked or diverted, officially according to the Drug Enforcement Agency. So we know it does happen. . . . A child is prescribed this thing--Ritalin, or another medication for treatment purposes. And if it's not carefully monitored or watched, it's possible that it could end up being sold on the street. So the restrictions are appropriate.

There's a lot of confusion out there as to whether these medications--Ritalin, methylphenidate, Adderall--are similar to cocaine. Can you dispel that myth once and for all?

The various stimulant agents can all potentially be abused. It really has less to do with the exact specifics of the chemical structure, and that's not what you should be focusing on. There are similarities across some of these agents. . . . But that's not a really good argument. There's single atom differences between some things that are therapeutic and some things that are poisonous. . . . There's one tiny chemical structure different between ethyl alcohol that we drink for recreational purposes, and other forms of alcohol that make you blind--just a tiny little switch in the chemical structure. So that's not where the story's told.

The story's told on research data that shows, "Is this abused? How much is it abused?" Cocaine is clearly abused. Cocaine is a street drug. Cocaine is imported illegally into this country. . . . We know Ritalin can be abused. It's a tiny amount of what's going on right now with Ritalin nowadays, compared to the medicinal use, but it's part of the story and it should be watched carefully. . . .

Has Ritalin abuse risen dramatically in recent years? There's no evidence from the DEA or from the National Institute for Drug Abuse when they've actually done their studies. There doesn't seem to be any major new trend. But they've got their eye on it. . . .

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