Ritalin: miracle drug or cop-out?

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IMAGINE yourself sitting in a classroom—say, a fourth-grade social-studies class. There is a teacher at the front of the room, but a groundskeeper mowing grass outside captures your attention instead. When the mower moves away, however, you feel bored and restless. Pretty soon your swinging feet slam into the seat in front of you. The attentive student sitting there yelps and the teacher interrupts the class to ask what the problem is. This sudden activity jolts you back into focus; at least something interesting is happening. You're beyond feeling embarrassed about being the center of this kind of attention. It happens all the time, and you have quite a reputation for this sort of thing. And besides, it isn't really your fault. They all say you probably have ADD or ADHD or something like that and can't help but act this way. It's just the way life is for some kids.

Scenes like this one, with endless variations, are played out across the United States every day in classrooms, on playgrounds, and in homes. The American Psychiatric Association's
(APA’s) Diagnostic and Statistical Manual, Version IV (DSM-IV), says that when a pattern of such behavior persists for six months or longer, and occurs in at least two different settings (e.g., in the classroom and at home), it may meet the criteria for a diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD). The combination of attention deficit and hyperactivity is common, but either can, and often does, occur without the other. Boys are between five and nine times as likely to be diagnosed with ADHD as girls, although many researchers are now suggesting that there may be many more girls who have an attention deficit but aren’t diagnosed because they aren’t hyperactive or impulsive and so don’t cause the kinds of problems that lead to parental or teacher intervention. And ADHD is no longer associated with just middle childhood; it is being diagnosed with increasing frequency in teenagers, adults, and even preschoolers.

**Ritalin’s supporters and critics**

What, exactly, is ADHD? The APA considers it a mental disorder, which it defines as a pattern of thought and behavior associated with distress and impairment of functioning resulting from some dysfunction within the individual. In the case of ADHD, the most quickly noticed behavioral and psychological patterns are the hyperactivity and inattentiveness described above. Such children typically don’t finish their homework, can’t complete class assignments or exams in the time allowed, and are generally disorganized and forgetful. About one in five, most often those with a diagnosis of impulsivity or hyperactivity, tends to be socially inept and isolated due to an inability to understand or follow the rules that govern civil human interaction. The adult version of the disorder shows the same patterns, rescaled to the tasks and settings of the grown-up world.

At first glance, these behavioral patterns seem to count as impairments of functioning. If that is so, then it isn’t a big step to conclude that some intervention is warranted. But the ADHD diagnosis has become highly controversial in recent years, with much of the controversy focused around the increasing use of the drug methylphenidate hydrochloride, an
amphetamine, more popularly known by its trade name "Ritalin," as the treatment of choice.

Although Ritalin is sometimes used for the treatment of other conditions, ADHD accounts for the overwhelming majority of prescriptions for it, and these have proliferated since 1990. Figures published in the August 12, 1996 issue of Forbes magazine show a fourfold increase in the rate of methylphenidate consumption between 1989 and 1994, a rise so dramatic that the U.S. Drug Enforcement Agency asked the United Nations' International Narcotics Control Board to look into the situation. The United Nations released a report in February of 1996 expressing concern over the discovery that 10 percent to 12 percent of all male school children in the United States currently take the drug, a rate far surpassing that in any other country in the world. Indeed, citizens of the United States, most of them well below the legal drinking or smoking age, now consume over 90 percent of the 8.5 tons of methylphenidate produced worldwide each year.

There is something odd, if not downright ironic, about the picture of millions of American school children filing out of "drug-awareness" classes to line up in the school nurse's office for their midday dose of amphetamine. It is this sort of image that fires the imaginations of Ritalin's critics—critics like child psychiatrist Carl L. Kline of the University of British Columbia who was reported in the August 4, 1991 New York Times Education Supplement as saying that Ritalin is nothing more than a street drug being administered to cover the fact that we don't know what's going on with these children.

Proponents, on the other hand, include many parents like Jane Leavy, who wrote an impassioned defense of the drug's use for the March 18, 1996 issue of Newsweek. She documents dramatic improvements in her son's academic and social performance thanks to Ritalin. Similar testimonials can be found in the growing number of ADHD discussions on the internet. These parents are staunch defenders of Ritalin—this miraculous drug has relieved their children of debilitating stress and unhappiness, they say. Indeed, a temporary shortage of Ritalin, in 1993, following the government's failure to give timely approval to Ciba Pharmaceuticals (Ritalin's manufac-
turer) to increase production, led to a widely reported public outcry and weeks of high anxiety among parents who feared being without the little yellow pill. For these people, the child's trip to the nurse's office is far from ironic; it is a pilgrimage in honor of one of the great successes of modern psychopharmacology.

**Causes of ADHD**

Discovering which view represents the better understanding of Ritalin and the condition it is intended to treat is not quite as simple as talk-show discussions and magazine articles sometimes make it seem. The difficulties begin with the fact that no one really understands the etiology of ADHD. Environmental factors from lead to sugar and food additives have been blamed, but there is no clear empirical support for such claims. Nor have investigators been able to explain the disorder by appeal to parenting styles or other socialization factors. Instead, what has emerged in recent years is mounting evidence that the problem runs in families. Among monozygotic (genetically identical) twins, when one twin is diagnosed with ADHD the other also receives the diagnosis 51 percent of the time. In contrast, among dizygotic twins, no more related to each other genetically than ordinary siblings, the concordance rate is only 33 percent. Combined with the fact that adoption studies show that the relationship runs more strongly in genetic families than in the family of upbringing, these data suggest that there is a genetic contribution to whatever is going on in ADHD.

This does not mean, however, that ADHD is genetically determined. If it were, then the concordance rate for monozygotic twins would be 100 percent, as it is for eye color. Rather, it means that there may be something in the genetic blueprint for wiring up the brains of some people which disposes them to the pattern of thought and action that gets labeled ADHD. At best, however, this is but a small part of the story, for it does not tell us what kinds of experiences in the world act together with this genetic disposition to produce the ADHD pattern. Most researchers are now convinced that there is no single answer to that question; it seems increasingly likely that
there are many different paths to the syndrome. That makes it difficult to offer simple prescriptions for preventing the ADHD pattern from developing. The best the psychiatric community has to offer is treatment once ADHD does develop, and, at the moment, the most popular treatments involve stimulant drugs like Ritalin.

The brain on Ritalin

Interestingly, the effectiveness of Ritalin and similar stimulants in changing the behavior of ADHD children has led researchers to think that they know what is different about the brains of those afflicted with ADHD. One of the most systematic attempts to piece together this puzzle has been made by James McCracken, professor of psychiatry at UCLA and his colleagues Steven Pliszka and James Maas, both professors of psychiatry at the University of Texas Health Science Center in San Antonio. Writing in the March 1996 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, they proposed what is known in the community of ADHD researchers as the “catecholamine hypothesis” to explain what is wrong in the brains of people with attentional dysfunction. It’s worth spending a little time trying to understand this theory because knowing just what is going on in ADHD patients helps to clarify what is really at stake in the controversy over Ritalin.

The catecholamines referred to in the phrase “catecholamine hypothesis” are among the dozens of special chemicals in the brain, known as neurotransmitters, that make it possible for the millions of nerve cells that make up that organ to communicate with each other. When a nerve cell “fires,” it releases tiny amounts of these chemicals into the small gaps, called synapses, that separate it from the cells to which it sends connections. These chemicals diffuse across the gap and attach themselves to special receptors on the receiving cell. Upon attaching, they change the chemical balance inside the receiving cell, making it more or less likely to fire in its own turn. All of the activities of the mind, including those that make it possible for you to read these sentences, are the result of quadrillions of such events taking place every second in the brain.
But these electrochemical processes must occur at the right levels of intensity and in the right patterns for the mind to function effectively. Too much of a neurotransmitter, or too little, being released in various parts of the brain can lead to a variety of disorders. For example, a deficit of a neurotransmitter called dopamine, one of the main classes of catecholamines, means that it can't send the right messages to control the contractions in the body's muscles, and one sees, as a result, the tremors of Parkinson's disease.

Pliszka, McCracken, and Maas have proposed that ADHD is such a neurotransmitter dysfunction, in this case a catecholamine imbalance. The catecholamines are used by many different circuits in the brain, but these researchers suggest that when there is an imbalance in the circuits that control attention, some form of ADHD is the result. Although these are among the most complex systems in all of nature, the basic logic of their hypothesis is simple enough. Controlling attention means that one has to be able to do two things. On the one hand, one has to be able to stay focused on a task or activity in the face of unavoidable distractions from the world outside and from one's own thoughts and sensations. But there has to be a way to disengage and then shift attention to a different activity if the need arises. A person's being too focused and unable to disengage can be just as much a problem as his not being able to stay focused in the first place. A balance must be struck, and that's what the attention circuits are supposed to do.

But what is the right balance? The answer is, and this is the most important point, the right balance must be appropriate to the kinds of tasks and situations one encounters. The balance is likely to be different for someone trading commodities in the pit of the Chicago Mercantile Exchange, a surgeon performing a delicate operation in a hospital, or a parent trying to cook dinner and keep an eye on the baby at the same time. And the precise nature of that balance is related in a complex way to the balance of the catecholamines in the attention circuits.

Stimulant drugs such as Ritalin affect that balance by increasing the amount of time that catecholamine molecules remain active in certain synapses. Exactly where the balance is
reset is still unclear and may vary from one person to the next. The complex neurophysiology of these circuits may also help to explain why many school-age children, and even more preschoolers and adults, don't seem to respond positively to methylphenidate but do respond to other stimulants like dextroamphetamine. These drugs are very similar in their effects, but the differences can be important in a circuit this complex. About 70 percent of the children diagnosed with ADHD will respond to one of the amphetamines, most of them to Ritalin. Of the remaining 30 percent, at least one-half will show improvement when they are given one of a class of anti-depressant drugs also known to affect the catecholamine neurotransmitters. And some children do not respond to any of these drug therapies.

The history of ADHD diagnosis

So far there is no way to know before the fact which drugs, if any, will be useful for a given child. Only trial and error reveals which drug treatment will improve the troublesome pattern of behavior. And that suggests that the diagnostic criteria for establishing the presence of ADHD are incomplete.

Indeed, although many physicians use the drug as a diagnostic tool—in other words, if Ritalin seems to improve attention, the patient is assumed to have ADHD—an improvement in attentional control after taking a drug like Ritalin does not, in fact, establish the diagnosis of ADHD. Studies conducted during the mid seventies to early eighties by Judith Rapaport of the National Institutes of Mental Health clearly showed that stimulant drugs improve the performance of most people, regardless of whether they have a diagnosis of ADHD, on tasks requiring good attention. Indeed, this probably explains the high levels of "self-medication" around the world (stimulants like caffeine and nicotine, for example). Particularly interesting is the fact that cocaine, still reputed to be the illegal drug of choice in the world of the young, upwardly mobile, and highly focused crowd, has a psychopharmacology that is very similar to that of methylphenidate. In short, even if you have never been diagnosed as having a problem paying attention, many of these drugs will improve your focus and perfor-
mance. The fact that a child is more attentive while taking Ritalin doesn't then mean that he has a documentable mental disorder.

So how is it decided that a child, or adult, should be considered attentionally disordered? The answer has varied over the last 40 years. In 1957, the first APA Diagnostic and Statistical Manual contained no mention of any disorder remotely like ADHD. By 1968, however, when DSM-II was published, there was a new diagnostic category known as "hyperkinetic reaction of childhood." The use of the term "reaction" here is significant, because the APA makes a distinction between a disorder and a reaction, the latter suggesting a milder, possibly less chronic condition. It wasn't until the appearance of DSM-III, in 1980, that attention deficit disorder or ADD was recognized. At that time, a distinction was made between ADD with hyperactivity (ADD/H) and without (ADD/WO). By 1987, the APA found it necessary to revise its manual again, and, in DSM-III-R (for revised), it was decided that there was a single dimension of disorder known by the now-familiar ADHD designation. However, by the time of the 1994 publication of DSM-IV, diagnosticians were convinced that the earlier DSM-III distinctions had been closer to the mark, and they proposed the current classification system with its three subtypes (with hyperactivity only, with inattention only, and the combined form).

Why has it been so difficult to stabilize the diagnostic criteria for ADHD? There are several possible answers. One of them is that the disorder itself is subtle and difficult to detect in all but extreme cases. This explanation is similar to ones that physicians offer when challenged to defend the diagnosis of chronic fatigue syndrome, a medical condition that, like ADHD, wasn't even in the diagnostician's toolbox a few decades ago. One who wanted to defend the diagnosis could argue that the disorders were known, at least in extreme cases, but that there were other, more folk-psychological explanations for these patterns which prevented people from seeing them as true disorders. People with chronic fatigue syndrome were simply thought to be "malingering." And children with ADHD were thought to be either "slow," if the problem was inattention, or "wild," if the problem was impulsivity. The
shift to viewing ADHD as a mental disorder could be seen, from this vantage, as an enlightened move.

But there is another reason why the criteria for ADHD might have been so difficult to articulate, and it calls into question the very foundation of the APA's diagnostic system. The APA has made the decision to formulate its diagnoses as categories of disorder. This means that one either does or does not have ADHD, or obsessive-compulsive disorder, or conduct disorder, or what-have-you. The alternative would be to focus on dimensions of difference. Our growing understanding of how we pay attention makes it clear that attentional capacities are measurable on dimensions of persistence, distractibility, impulsivity, flexibility, and control. These different factors define a multi-dimensional space of possibilities for how we pay attention, and each of us occupies a unique region in that space.

From this perspective, diagnosing a child as having an attentional disorder seems to require drawing lines along the various continua and deciding that people on one side are normal and those on the other are not. Somewhere between the person with exquisite control over the focus of his attention and the befuddled scatterbrain, we judge the attention-control system to be broken and in need of treatment.

**Theory and practice of diagnosis**

But how are we to decide which side of the line a given person is on? There are, as it turns out, two answers to this question. One is the official answer, and the other reflects what actually happens in the offices of school psychologists and pediatricians.

Officially, experts make very specific and stringent recommendations about how to correctly diagnose ADHD. Dennis Cantwell, in a recent review of the last decade of research on ADHD for the August 1996 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*, summarizes the current recommendations. The diagnosis should begin with thorough interviews of anyone who acts as parent to the child. The goal is to establish, in detail, under what circumstances the presenting symptoms occur and to take a complete developmental, medical, and family history. Following these inter-
views, the clinician should interview the child in order to elicit his view of the problem. This interview should include screening for other problems that might be the real source of difficulty, including other mental disorders (depression, anxiety, hallucinations, etc.). The child should also be given a thorough medical examination to rule out neurological or sensory problems (poor hearing or eyesight, for example) as the cause of symptoms. The child should then be given tests of intelligence and achievement, and the clinician should evaluate questionnaires filled out by both parents and teachers. These questionnaires ask the respondent to indicate the degree to which the child displays the patterns of behavior that are considered markers for ADHD. Further tests may be required to rule out possible problems that emerge during this lengthy examination.

In reality, few physicians report anything like this level of scrutiny before prescribing treatment. In a recent survey of pediatricians, published in the *Archives of Pediatric and Adolescent Medicine*, nearly 50 percent of doctors confess to spending an hour or less with a child before making a diagnosis and prescribing medication (usually Ritalin). Obviously, the thorough regimen of examinations suggested by the experts can’t be performed in such a short period of time. What should make this particularly worrisome, even for those who are willing to defend the current criteria for diagnosing ADHD, are recent findings by Mark Wolraich and his colleagues at the Vanderbilt University Child Development Center that as many as two-thirds of all children who meet the DSM-IV criteria for ADHD have other problems as well. These are referred to in the psychiatric community as “comorbid conditions,” and they most often include things like anxiety and so-called conduct disorders. This is particularly significant information to have when prescribing medications, because stimulant drugs actually may be counterproductive for children with certain of these problems. Combine this with the finding by Linda Copeland and her colleagues, reported in 1987 in *Developmental and Behavioral Pediatrics*, that most pediatricians do not adequately monitor the medications of their ADHD patients once they have prescribed them and you have a troubling situation indeed.
If diagnoses and follow-ups are not being conducted by experts' examinations, then how are they being made? The research literature suggests that it is behavioral ratings of teachers and parents which are most often used to assign the ADHD classification. The parent or teacher is presented with a number of statements such as, "Is easily distracted by extraneous stimuli," and is asked to indicate the degree to which this statement applies to the child. Responses to all of the questions are summed, and the result is compared to established norms. If the child falls outside this normative range, he receives the ADHD diagnosis. In other words, a line is drawn beyond which an individual difference is labeled a pathology.

The problem, of course, is that the decision about where to draw that line is a judgment call. Wolraich and his colleagues applied the criteria for ADHD from both DSM-III-R and DSM-IV to the same sample of 8,258 children and found that 7.3 percent of them have ADHD according to DSM-III-R, while more than half again as many, 11.4 percent, qualify using DSM-IV criteria. Even using the same rating scales yields different percentages depending on the standard one uses. If a teacher has to say that various characteristics, like distractibility or forgetfulness, very much describe a child before ADHD is diagnosed, the proportion of ADHD children may run as low as 4 percent. But if the teacher can say either that the traits are very much characteristic of the child or only pretty much so, the proportion rises to over 18 percent.

So this is the situation in which we find ourselves. The psychiatric community has decided to collapse a complex, multidimensional pattern of behavior into two categories. One it considers normal; the other it considers pathological (with three variations) and labels ADHD. Meanwhile, treating physicians have collapsed a thorough diagnosis regime into a one-hour visit. As a result, diagnosis and treatment outside the research laboratory vary widely: The number of grams of Ritalin used per 100 population ranges from a low of 0.25 grams in Hawaii to a high of 2.36 grams in Georgia, a nearly tenfold difference. Nevertheless, taking the country as a whole, we learn that the overall trend is toward increasing use of the label ADHD for school-age children and its gradual extension to
cover adults and pre-schoolers as well. And this growth in the number of diagnosed cases is accompanied by a dramatic increase in the last decade in the use of certain stimulant drugs to treat the symptoms of the disorder.

The new therapeutic education

What remains unclear is why there should be an increase in the use of the diagnosis. After all, the flexibility of the criteria for considering a child to have ADHD could just as well have been used to decrease the number of children so diagnosed. Why have the numbers gone up?

There is no existing research to answer this question definitively. The research suggests that changes in the DSM criteria may have had an effect on the overall numbers of children who are considered to have ADHD, but that doesn't explain why the percentages of children who are diagnosed and put on medication vary from one part of the country to another. The best we can do in response to this question is to propose hypotheses for future research. To do that, however, it helps to have a few additional facts about the typical sequence of events leading up to a diagnosis of ADHD.

The precipitating events almost always take place at school. It is no accident that the disorder was long considered to be a problem that did not arise until about the age of five. The growth in the number of children attending nursery schools, beginning at age three or four, probably then accounts for the recent rise in diagnoses of the disorder at these younger ages. What this means is that the first suggestion that a child might have ADHD is usually made by a teacher, often during a parent-teacher conference, and not by a parent. The teacher already may have asked the school psychologist to observe the child and filled out one of the teacher rating forms for assessing attention and impulsivity. The teacher may then suggest an evaluation by the family's pediatrician or some other specialist.

Once this formal evaluation begins, as we have seen, the process can move with great rapidity. A few minutes with the child, some discussion with a concerned parent, and perhaps a look at the teacher's rating forms and a report from the school
psychologist, and the doctor makes a diagnosis of ADHD. Medication is prescribed, most often Ritalin initially, and the child officially joins the ranks of the attentionally impaired.

But why of late are more teachers making such referrals? The most innocent explanation is that as teachers, and to some degree parents as well, have become better educated about this problem, they have tended to seek professional help when signs of ADHD are first detected. Indeed, there is a trend underway toward making the school an extension of the therapy establishment. For example, school psychologists have been very active proponents of the need for increased mental-health services for school children. Beth Doll, of the University of Colorado at Denver, writing in the Winter 1996 issue of the School Psychology Quarterly, urges the establishment of training programs that would "create therapeutic schools in which ownership for students' mental health is fostered among every teacher and administrator in a building." This is newspeak for the idea that teachers and administrators have to be taught how to think and act as therapists as well as educators. This vision of the school as a mental-health facility may already be affecting how teachers and school psychologists view their roles in the system, with the rise in the number of children with the ADHD diagnosis as a kind of lagging indicator of these changes.

Not everyone in the school system, however, seems eager to embrace the therapeutic model of the school. Cost-conscious school administrators and school boards are leery of this new focus on mental health. And they cringe every time another student is added to the ADHD population in a school, for many parents are being informed by physicians who diagnose their children that ADHD counts legally as a disability and therefore qualifies the child for special treatment under the Americans with Disabilities Act. By this law, the school system is obligated to provide "equal access" to the curriculum for such children, which may mean paying for special remedial services or other therapies. Given a fixed school budget, the funds for such services have to come out of other programs, with net negative results for other students in the school. So from the standpoint of school administrators, there is a financial disincentive to ADHD diagnoses.
Pressure to succeed

However, it may turn out that state departments of education and local school boards are finding themselves nonetheless hoist with their own petard. It may prove significant that the rise in the number of referrals for ADHD tracks the adoption throughout the country of outcome-based educational goals. Outcome-based systems are predicated on the idea that every child can and should be brought to some high minimal standard of performance in the curriculum. These systems are motivated philosophically by an egalitarian view of society; we are all entitled, on this view, to an equally effective education at the public’s expense.

But once you have adopted such a system, teachers cannot respond to uncooperative and inattentive students by simply passing them on to the next grade. Outcome-based programs make the teacher directly accountable for the child’s performance. Teachers now become desperate seekers after anything that will enable them to improve the child’s performance to the mandated level. Hence their eagerness to suggest the quick fix of drug therapy if the child’s problem seems attentional.

It would require careful and elaborate research to test this hypothesis thoroughly, but a crude check of its plausibility can be made by comparing the rate of Ritalin consumption in the 50 states and District of Columbia with data from the U.S. Census on whether or not the state has some sort of exit exam or competency requirement for graduation from high school. The latter data are crude, require some interpretation, and are not quite as contemporary as the data for Ritalin consumption; so the result must be viewed as very tentative. But it is interesting that states with competency or exit requirements have higher levels of Ritalin consumption than states that do not, on average. The difference is not large, amounting on average to only about .3 grams per 100 population, but it is statistically significant. This means that it is at least possible that the pressure to get students to perform to high levels in the public-school classroom is leading teachers to promote the ADHD diagnosis and subsequent treatment with a drug that improves the child’s behavior.

Indeed, the data on how Ritalin affects performance are consistent with this view. The child for whom Ritalin (or one
of the other drugs) works tends to remain "on task" longer and, therefore, tends to complete more work. This includes work on exams and homework assignments, with the result that the child's grades may actually show improvement. The child tends to become more cooperative, to follow directions better, and thus to get along better with other children and with the teacher. This has the beneficial side effect of improving the classroom environment by reducing disruptions and time away from other students, and so increases the teacher's effectiveness with the class as a whole.

What Ritalin does not do, and this is a finding about which proponents of the ADHD diagnosis tend to be defensive, is to improve long-term achievement-test scores. The drug simply makes the child more manageable and better able to work to the level of the system's expectations. It does not seem to produce long-term changes in cognitive functioning.

Replacing Ritalin with school choice

It is tempting to view this pattern as suggesting that the ADHD diagnosis provides teachers with a new technique for regaining control of the classroom in a world where many of the traditional methods of control have been eliminated. Drugs have replaced the reprimand.

But it seems to me that the real problem may be that the concept of compulsory, cookie-cutter education needs rethinking. In spite of the rhetoric in schools of education about the importance of taking into account the individual needs of the children in a classroom, the current system of public education is designed to make that nearly impossible. State curriculum guidelines and requirements, coupled with further requirements from the local community, prevent teachers from making any serious effort to tailor materials and assignments to the differing abilities and dispositions of individual children. Nor is there any mechanism, of the sort one would find in a school-choice-based system of education, for parents to seek out schools tailored to the temperaments and capabilities of their children. Instead, it becomes necessary to find ways of making children able to perform in the environment as they find it. And, in late twentieth-century America, when it is difficult or inconvenient to change the environment, we
don't think twice about changing the brain of the person who has to live in it. The rise in consumption of Ritalin is only one manifestation of this cultural practice. Consider Prozac or, in previous decades, Valium.

None of this should be taken to suggest that there are no cases of genuine brain damage or dysfunction that require medical intervention. There have always been diseases of the brain, as of any other organ, and they should be treated as such. But difference does not automatically equal disease. Is changing the child's brain chemistry, by prescribing Ritalin-like drugs, really the most appropriate response to the child who doesn't perform well in the modern school environment? Perhaps it's time we asked ourselves whether the fact that so many children can't learn well in our schools is a reflection on the schools, not the children.