ADHD: Fact, Fiction, or Somewhere In Between
BY CHARLES WALKER

“. . . there is no new thing under the sun” (Ecc. 1:9).

“Even a child is known by his doings, whether his work be pure, and whether it be right” (Prov. 20:11).

“A merry heart doeth good like a medicine: but a broken spirit drieth the bones” (Prov. 17:22).

“And, ye fathers, provoke not your children to wrath: but bring them up in the nurture and admonitions of the Lord” (Eph. 6:4).

Definition

Attention Deficit /Hyperactivity Disorder (ADHD) is defined by the American Psychiatric Association (APA) as “a persistent pattern of inattention and/or hyperactivity that is more frequent and severe than is typically observed in individuals at a comparable level of development.” The term ADHD is used interchangeably with Attention Deficit Disorder (ADD); however, the two terms are not in the truest sense considered synonyms. In laymen terms, ADHD means “you are different because you have a disorder—a psychiatric disorder.”

Diagnostic Criteria

What criteria are used by licensed professionals to diagnosis ADHD? How reliable is this criteria? Is ADHD fact, or fiction, or somewhere in-between?

The criteria used by doctors, psychiatrists, and psychologists to identify ADHD in children and adults are defined and listed in the Diagnostic and Statistical Manual-IV-rev. (DSM-IV-TR). The complete list of ADHD symptoms and the general guidelines used by qualified professionals to determine whether a child or adult is ADHD are in Figure 1. These criteria are reproduced exactly as listed in the DSM-IVTR Manual.

The establishment of ADHD as a psychiatric disorder was defined and announced by licensed health care practitioners who periodically discuss new disorders that could potentially be added to the disorders listed in the DSM-IV-TR. From these discussions new psychiatric disorders are added to the existing list.

As we look at the diagnostic criteria listed in Figure 1, keep in mind that a positive ADHD diagnosis must be based on this criteria. Theoretically, unless the student exhibits behavior in a prescribed number of symptoms (18 symptoms in all) listed in the DSM-IV-TR Manual, the student cannot, supposedly, be labeled as ADHD. In analyzing the criteria in Figure 1, the same criteria used by health professionals, it is vitally
important that Christian school teachers thoroughly understand the following interpretation guidelines:

1. Six or more of the nine *inattention* symptoms have persisted for at least six months to a degree that is maladaptive and inconsistent with development level.

2. Six or more of the nine symptoms of hyperactivity impulsively have persisted for at least six months to a degree that is maladaptive and inconsistent with developmental level.

3. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age seven years.

4. Some impairments from the list of symptoms is present in two or more settings (e.g., at school, at work, and at home).

5. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

The *DSM-IV-TR Manual*, referred to as “the DSM Manual,” is to licensed healthcare practitioners what the Bible is to preachers.

**Behavioral Symptoms**

Pharmaceutical medicine is the most commonly used procedure in treating ADHD. In fact, drugs are used more than all other forms of ADHD treatments combined. This includes biblical counseling, rational psychotherapy, family therapy, family counseling, improved education settings, diet, and other non-drug treatments. The medical and psychiatric professions, as a whole, reject the sin nature of man and the value of biblical counseling as a legitimate way to treat ADHD. In most instances, they also ignore natural treatments.

With this said, the 2000 *DSM-IV-TR Manual* divides ADHD symptoms into three groups or categories:

(1) Inattention—poor attendance

(2) Hyperactivity—physical restlessness, fidgety

(3) Impulsivity—not thinking before acting.

What do these terms mean in relation to ADHD? First, let’s look at “inattention,” commonly called distractibility. The major inattentive indicators are as follows:

• Does not seem to listen
• Fails to finish assigned tasks
• Often loses things
• Can’t concentrate
• Easily distracted
• Daydreams
• Requires frequent redirection
• Can be very quiet

The second symptoms group is “hyperactivity,” often referred to as over arousal. The major hyperactivity indicators are as follows:
• Restlessness
• Can’t sit still
• Talks excessively
• Fidgeting
• Always on the go
• Easy arousal
• Lots of body movement

The third group of ADHD characteristic is “impulsivity,” commonly called behavioral disinhibition. The major impulsiveness indicators are as follows:
• Rushing into things
• Careless errors
• Risk taking
• Taking dares
• Accident/injury prone
• Impatience
• Interruptions

These behaviors could result from a number of school and home situations, including but not limited to unrealistic academic and behavior expectations, boredom, disorderly classrooms, peer pressure, self-imposed expectations, parents in conflict, poor parenting, lack of parental love and attention, poor self image, deprived of proper nutrition, lack of sleep, under-active thyroid, and the lack of physical exercise. Generally speaking, these types of behavior either get on the parents’ or teachers’ nerves or they demand the parents’ or teachers’ attention and time, but it is overly zealous for anyone to say that such disorders are ADHD symptoms. The number of treated ADHD patients in 2000 was estimated between five and six million (Block, 2001) and the number grows annually.

Phyllis Schlafly, president of Eagle Forum, says, “If you look at the list of symptoms on which people diagnose ADHD, you will find that they are characteristics of most normal boys: unable to sit still, has difficulty following directions, wants to run around, and may fidget if required to sit too long. . . . This is just normal ‘boy behavior.’ ”

Not Everyone Agrees

Before anyone swallows hook-line-and-sinker the DSMIV-TR definition and classification guidelines for diagnosing ADHD, one should consider the conflicting statements made by the licensed practitioners involved in adopting the DSMIV-TR ADHD criteria. The DSM-IV-TR Manual states that ADHD is primarily caused by adults, primarily parents and teachers—parents more than teachers, for not doing their jobs properly. Quoting from the 2000 edition of the DSM-IV-TR, pages 86 and 87:

Symptoms typically worsen in situations that require sustained attention or mental effort or that lack intrinsic appeal or novelty (e.g., listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks). Signs of the disorder may be minimal or absent when the person is under strict control, is in a novel setting, is engaged in especially interesting activities, is in a one-to-one situation (e.g., the clinician’s office), or while the person experiences frequent rewards for appropriate behavior.

Dr. Peter Breggin, a highly respected and revered psychiatrist, in his book, The Ritalin Fact Book, offers an insightful analysis of the DSM Manual comments. Think with Dr. Breggin, who, by the way, is often referred to as the “conscience of psychiatry,” as he breaks this DSM-IV-TR paragraph into its parts and applies reason to its meaning.

The “symptoms” will appear or worsen in situations that “lack intrinsic appeal or novelty,” i.e., that bore the child to death. But why should this be blamed on a disorder in the child rather than on the boredom of the classroom? Do we really
want to label children mentally disordered because they don’t respond in a docile fashion to “listening to classroom teachers, doing class assignments, listening to or reading lengthy materials, or working on monotonous, repetitive tasks”?

The symptoms will improve or even disappear and become “absent” when the child is in a “novel setting” or is “engaged in especially interesting activities.” What can be concluded? A good classroom that engages and inspires children will eradicate ADHD from many a child’s life.

The symptoms can also improve or disappear when the child is “in a one-to-one situation (e.g., the clinician’s office).” How can this be? Many of these children are so starved for adult attention that their symptoms may disappear in response to the crumbs of attention they receive during a few minutes spent with a doctor. Most of these children are especially starved for one-to-one contact with a father or father-like person, so they are especially prone to behave well in the presence of a male doctor.

The “symptoms” will also improve or even disappear if the child is “under strict control.” ADHD is a disease that can go away when the child is given sufficient discipline or supervision. Why is this? Because many of these children have never been given sufficiently strict control, or they have been given contradictory, inconsistent control that at times is overly restrictive.

The “symptoms” will also improve or even disappear when the child “experiences frequent rewards for appropriate behavior.” What does this tell us? One of the most obvious principles of effective parenting—rewarding good behavior—is often sufficient to make this supposed disorder disappear.

### ADHD and Scripture

The Bible is the greatest psychology book ever written; the Bible is also the greatest child-rearing book available to parents and professional health care practitioners. Christian school educators and parents need not abdicate the truths of Scripture as conclusions are drawn about ADHD. To ignore biblical truths and principles in ADHD discussions is inconceivable. For example, the Bible teaches the following absolute truths:

- Every child is wonderfully created; God made no mistakes.
- God created every child with a marvelous destiny.
• God will help you to help your students (child) to achieve his or her calling.

• There is no challenge before you that’s bigger than God.

• God “. . . will never leave thee, nor forsake thee” (Heb. 13:5)

Interesting, those who feel ADHD is a social disorder or disease adhere to presuppositions diametrically opposed to Scripture. Consider the following humanistic beliefs regarding ADHD and how to treat it.

1. Some children who cannot sit still and pay attention in school have a biologically-based behavior disorder.

2. Some children cannot be held accountable for their behavior.

3. Drugs are the treatment of choice.

4. Biblical counseling is inappropriate.

**Some Research Facts to Consider**

Before proceeding with our “Fact vs. Fiction or Somewhere In-Between” comments, we need to look at what research says about ADHD.

• Five to 7 percent of school-aged children have been diagnosed with ADHD.

• Another 5 to 10 percent of school-aged children have been diagnosed as partial ADHD.

• Another 15 to 20 percent of school-aged children show transient behaviors suggestive of ADHD.

• Boys are three times more likely than girls to be diagnosed as having ADHD.

• Symptoms decrease with age but 50 to 60 percent of children still manifest symptoms into adulthood.

• ADHD is the most commonly diagnosed behavioral disorder among children.

• Some feel ADHD is genetically transmitted in 70 to 95 percent of cases.

• ADHD affects the individual and the whole family.

• ADHD is intensely scrutinized by the public.

• Twenty-five percent of the students in some classrooms are on Ritalin.
• Only 5 to 10 percent of ADHD students will complete college.

• Fifty to 70 percent of ADHD students have few or no friends.

• Seventy to 80 percent of ADHD students will underperform at work.

• Forty to 50 percent of ADHD students will engage in antisocial activities.

• ADHD students are more likely to experience teen pregnancy and sexually transmitted diseases.

• ADHD students have more accidents and speed excessively.

• ADHD students experience depression and personality disorders.

• Thirty-five percent of students with learning disabilities drop out of school.

• Thirty percent of adolescents with learning disabilities will be arrested three to five years out of high school.

• Previously undetected learning disabilities have been found in 50 percent of juvenile delinquents—once treated, their recidivism (relapse into previous condition) drops to just two percent.

These findings are alarming! But this question must be asked in regard to the research facts previously listed: “How accurate is the diagnosis process?” Most of these students are treated with drugs.

**Drug Stimulants**

Historically, the use of psychostimulants, commonly called stimulants, became acceptable in the medical and psychiatric professions in the 1960s, even though they were used on a lesser scale from the 1930s to 1960. Ritalin (methylphenidate) was introduced as a stimulant drug for ADHD in 1956. Ritalin, manufactured by Novartis, has become synonymous with the whole family of ADHD stimulant drugs. Other stimulant ADHD drugs include Adderall, Dexedrine, Focalin, Adderall XR, Ritalin LA, and Concerta. As popular as Ritalin has been in treating ADHD, Adderall is increasingly becoming the ADHD drug of choice.

In 1961, the Federal Drug Administration (FDA) approved the use of Ritalin for children with behavioral problems, namely ADHD. In 1975, 150,000 American children were taking Ritalin. This number increased to one million children in 1988 and six million (approximately one child out of every eight) in 2000 (Sax, 2000). The International Narcotics Control Board and the Drug Enforcement Administration reports that 90 percent of the world’s Ritalin is consumed in the United States; whereas, the United States comprises only 5 percent of the world’s population. Their research further states
that 10 to 12 percent of boys ranging in ages from 6 to 14 years take Ritalin. They further claim that “Methylphenidate (Ritalin) is one of the nation’s most commonly stolen and diverted substances.” The U. S. Department of Justice has confirmed “Ritalin [to be] a Schedule II stimulant similar to amphetamines and cocaine and has the same dependency profile as cocaine and other stimulants.”

“All stimulants,” according to Breggin (2002), “including Ritalin, Adderall, Focalin, and Concerta, work by putting a governor (what we use in buses and automobiles to reduce their maximum running speed) on the child’s brain, literally suppressing the brain’s ability to generate spontaneous mental life and behavior.” Drug-induced impairments will not make a student wiser or smarter; they will not make a student more thoughtful or better informed. On the other hand, they can only make children sit down, shut up, and do what they are told.

Breggin (2002) further states that stimulants work by impairing normal brain functions. “Children become less spontaneously active, more submissive, and more willing to focus on boring, rote tasks.” Furthermore, “Stimulants cause children to become biochemically impaired and injured by the drugs.” ADHD drugs have side effects, among which include loss of appetite, serious weight loss, insomnia, depression, headaches, stomachaches, bed-wetting, irritability, and dizziness.

The majority of psychiatrists, pediatricians, doctors, and psychologists continue to prescribe the use of ADHD drugs in spite of the numerous research reports that state severe psychological effects can be caused by the use of pharmaceutical drugs. Furthermore, no research has proven or claimed that Ritalin-type stimulants provide positive long-range results.

In a study entitled “Hyperactive Children as Teenagers: A Follow-up Study” (1971), 83 children were followed from two to five years after being diagnosed as hyperactive or as having Attention Deficit Disorder. Ninety-two percent of the children were treated with Ritalin. Results were as follows:

- Sixty percent of the children were still overactive and had poor schoolwork (the original reasons for being put on Ritalin), but in addition were now viewed as rebellious.
- Twenty-three percent had been taken to the police station one or more times.
- Fifty-nine percent had some contact with the police.
- Fifty-eight percent had failed one or more grades.
- Fifty-seven percent had reading difficulties.
- Forty-four percent had arithmetic difficulties.
- Seventy-eight percent found it hard to sit still and study.
• Fifty-nine percent were viewed as discipline problems at school.

• Eighty-three percent had trouble with frequent lying.

• Fifty-two percent were destructive.

• Thirty-four percent had threatened to kill their parents.

• Fifteen percent had talked of or attempted suicide.

**Impartial Research Study**

In November 1988, the National Institute of Health convened a three-day “Consensus Development Conference” on ADHD with an emphasis on how to treat ADHD. Whereas a number of ADHD experts linked ADHD to neurobiological disorders, no scientific evidence was presented to prove ADHD was a neurobiological disorder. The following consensus statements reflect their findings. These statements were prepared by a non-advocate, non-federal panel of experts who based their consensus statements on information gleaned from areas relevant to the consensus questions, questions and statements from conference attendees, and closed deliberations by the panel.

The consensus statements adopted in November 1988 by the National Institute of Health include the following:

1. ADHD is a commonly diagnosed behavioral disorder of childhood that represents a costly major public health problem.

2. Despite progress in the assessment, diagnosis, and treatment of ADHD, this disorder and its treatment have remained controversial, especially the use of psychostimulants for both short- and long-term treatment.

3. Although an independent diagnostic test for ADHD does not exist, there is evidence supporting the validity of the disorder.

4. Although trials are under way, conclusive recommendations concerning treatment for the long-term cannot be made presently.

5. There are wide variations in the use of psychostimulants across communities and physicians, suggesting no consensus regarding which ADHD patients should be treated with psychostimulants.

6. These problems point to the need for improved assessment, treatment, and follow-up of patients with ADHD.
7. After years of clinical research and experience with ADHD, our knowledge about the cause or causes of ADHD remains largely speculative. Consequently, we have no documented strategies for the prevention of ADHD.

Keep in mind that ADHD was diagnosed by the American Psychology Association as a *disorder* almost 50 years ago, yet, the National Institute of Health warns us to rethink what we have been told about ADHD. Also, based on the Consensus Development Conference’s findings, “An independent diagnostic test for ADHD does not exist.”

Not everyone agrees with the findings of the 1998 consensus group nor do they agree with those who *do not value* the use of psychostimulants in treating ADHD. For example, Harvey Parker, co-founder of Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), claims that their organization “provide[s] the best information in the world on ADD . . . Emotional difficulties including substance abuse are more likely to occur when a child with ADHD is not treated.” CHADD publishes the bi-monthly magazine *Attention* and has a website at www.chadd.org. Curiously, CHADD, a parents’ advocacy group, received almost one million dollars from 1991 to 1994 from Ciba Geigy (now Novartis) to support CHADD (Block, 2001). This insightful piece of data was reported by The Merrow Report in the PBS special, *ADD: A Dubious Diagnosis?* (Merrow, 1995).

**Treating ADHD**

Breggin (2002) says “[t]here is no doubt that there are kids who are bored, who are frustrated, and who are anxious. There’s no doubt that some kids don’t fit into our schools and some aren’t doing very well in their families, but there’s no evidence whatsoever that it’s a disease or medical disorder, it’s a child in conflict, it has to be dealt with in a conflict situation.” Dr. Peter Breggin opposes CHADD’s claims, advocating methods other than drugs, even though he would support psychostimulants in some cases, to address ADHD.

Mary Block, author of *No More ADHD*, states, “Every child deserves a complete medical work-up by a physician who understands that allergies, blood-sugar problems, learning problems, and diet and nutrition can affect how a child feels, thinks, and acts. . . . When a child has attention and behavior problems, it is not ADHD. These children don’t have psychiatric problems. They often have medical conditions or academic problems interfering with their attention and behavior.”

**Conclusion**

ADHD symptoms can be attributed to a variety of non-brain related problems, among which include nutritional deficiencies (diet), insufficient physical exercise, poor study skills, allergies, hypoglycemia, lack of essential vitamins, too much sugar, poor sleep patterns, learning problems, absence of parental love and discipline, and the lack of classroom love and discipline. There are numerous learning and health problems that
could cause attention and behavioral problems in children that can be addressed in ways other than psychostimulants.

The Scripture states, “Let no corrupt communication proceed out of your mouth, but that which is good to the use of edifying, that it may minister grace unto the hearers” (Eph. 4:29). Words are powerful. They can bring joy or sadness. Christian school educators need to watch carefully the words they use to describe the students they teach, in particular, the labels attached to children. For example, use high-energy in place of hyperactive; spontaneous instead of impulsive; creative as opposed to distractible; inspired instead of daydreamer; and sensitive as opposed to irritable.

Whereas occasions exist when carefully prescribed medication provides relief for some children, many more could be better helped by other methods. ADHD, as described by the present DSM Manual and diagnosed by the medical and psychiatric associations, lies somewhere between fact and fiction, closer to fiction.

**Editor’s Note:** In the next issue of the *Journal for Christian Educators*, the author will discuss alternatives to psychostimulants, along with ways the classroom teacher can help both the student and parents in dealing with the symptoms commonly associated with ADHD.

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**References**


Block, M. A. (2001). *No more ADHD: 10 steps to help improve our child’s attention & behavior without drugs!* Hurst, TX: Block System, Inc.


Criteria for Assessing ADHD (Figure 1)

The following criteria that is used for assessing ADHD is taken from:

(1) *The Diagnostic and Statistical Manual of Disorders IV (DSM-IV)*
[or]
(2) *DSM-IV-R “Diagnostic Criteria for Attention-Deficit/Hyperactivity Disorder*

Six (or more) of the following symptoms of inattention have persisted for at least 6 months to a degree that is maladaptive and inconsistent with development level:

**Inattention**

- often fails to give close attention to details or makes careless mistakes in schoolwork, work or other activities
- often has difficulty sustaining attention in tasks or play activities
- often does not seem to listen when spoken to directly
- often does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- often has difficulty organizing tasks and activities
- often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or home work)
- often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
- is often easily distracted by extraneous stimuli
- is often forgetful in daily activities

Six (or more) of the following symptoms of hyperactivity impulsively have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:
Hyperactivity

- often fidgets with hands or feet or squirms in seat
- often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
- often leaves seat in classroom or in other situations in which remaining seated is expected
- often has difficulty playing or engaging in leisure activities quietly
- is often “on the go” or often acts as if “driven by a motor”
- often talks excessively

Impulsivity

- often blurts out answers before questions have been completed
- often has difficulty awaiting turn
- often interrupts or intrudes on others (e.g., butts into conversations or games)

Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home). There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.