

**A DANGEROUS DIAGNOSIS:
THE SOCIAL CONSTRUCTION OF ATTENTION DEFICIT DISORDER/
HYPERACTIVITY DISORDER AMONG CHILDREN, AND ITS' TREATMENT**

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Independent Study
Capstone- Paper & Video Compilation
University Honors
HNRS-490-003H
American University
Washington, D.C.
April 29, 2005

INTRODUCTION

All of a sudden, it seems, millions of American children are said to be afflicted with mental illnesses. And they're being put on strong medications- over periods of years- as treatment. Isn't it time we stopped and looked at what the mental health establishment is getting us to do to our children? –Gary Null

This paper and video compilation investigate the nature of Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD), and how children are medicated for this condition with and without their and their parents' consent. Children, especially, are increasingly labeled with this "disorder" and medicated, yet many questions remain. Together, the paper and video will attempt to answer the uncertainties about ADD/ADHD, before more children are medicated for this curious condition.

With ADD and ADHD becoming one of the most commonly diagnosed, and misdiagnosed, disorders of childhood, and with the prescription of Ritalin and other powerful psychostimulant drugs reaching alarming proportions, it is time to take a fresh look at what ADD/ADHD is, and what it is not.

This paper and video will show that ADD and ADHD are socially constructed, as opposed to the conventional wisdom that says they are diseases. This means individuals have invented ADD and ADHD as disorders in order to medicate and control children, for what society feels is socially unacceptable behavior.

LITERATURE REVIEW

Recent reviews and conclusions among leading experts were reviewed for this paper. The literature shows the vast amounts of contradicting information on this subject.

Literature was reviewed that supports the current belief in ADD/ADHD, and discusses medication. Frank Lawless' 2004 book, *The ADD Answer*, as seen on the television program, Dr. Phil, is a step-by-step guide for parents. It consists of questionnaires, and action plans. He teaches parents how to identify their child's specific needs and deficits, and then outlines healing pathways that, he says, can improve functioning.

The ADHD E-Book is an article from the web site Pediatricneurology.com from 2005 that has several sections discussing ADD. There is a comprehensive summary of ADHD problems and treatment. It says people with ADD typically have problems with organization.

Russell Barkley is an online ADD consultant at ADD Consults. He has a current 2005

website. He says he interacts with thousands per week and calls himself an expert on the subject.

Voices from Fatherhood, Fathers, Sons, and ADHD, by Patrick Kilcarr, and Patricia Quinn (1997), offers chapters on ADHD, what it is and is not. It shows how ADHD affects parenting, fatherhood and families, managing ADHD, behavior management strategies, medication issues and living with ADHD, surviving adolescence, and also contains a list of resources.

ADD and ADHD Statistics, by Denise Witmer in 2004, looks at a new report released by the Centers for Disease Control and Prevention, about the number of elementary school children diagnosed with ADHD. It shows the prevalence of these children to use health care services in school.

What Is Attention Deficit Disorder? ADD or ADHD? is a 2005 article from the website ADDinschool.com that deals especially with teachers and students with ADD in an elementary school environment. It has definitions and characteristics of the disorder.

Literature was reviewed that discusses and questions the status and medication of ADD/ADHD. The 2004 *ADHD Medication Fact Sheet* is an article that describes common medications for ADHD, their side effects and benefits. It explains that the positive response of a child to stimulant medication does not confirm a diagnosis of ADHD.

Teresa Gallagher, in *Born To Explore! The Other Side of ADD* from 2005 describes the debate of if ADD is a disorder or not. It describes common arguments, and rebuttals, for belief in ADD: how the drugs work, caused by minor damage to forebrain, and neurological differences in the brain cause ADD. She does a great job of explaining these arguments and counterarguments.

Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder, by Martha Glock

and Peter Jensen in 1998, shows that despite the substantial progress in the assessment, diagnosis, and treatment of children and adults with ADHD, the disorder has remained controversial in many sectors. This increased availability and use of psycho stimulants has intensified the concerns about use, overuse, and abuse.

The Natural Solution to ADD/ADHD: Drugging Your Child is NOT the Answer! is a 2005 article from a website, *No More ADD*, that describes ADD/ADHD as a neurological condition. It has diagrams of the brain and definitions of the disorder. It lists common neural processing and behavioral traits of an ADD child. Shirley's Wellness Café is a website that discusses alternatives to drugs in a 2004 article, *Drug-Free Alternatives For Attention-Deficit Disorder Helping Children, Not Drugging Them*.

And finally, literature was reviewed that does not support the belief in ADD/ADHD, or is against the medication of children for this “disorder”. Peter Conrad and Joseph Schneider's 1992 *Deviance and Medicalization, From Badness to Sickness*, investigates the origins and contemporary consequences of the medicalization of deviance. They argue that medical work can lead to the creation of new medical norms, whose violation is deviance. They examine specific cases—madness, alcoholism, opiate addiction, homosexuality, delinquency, and child abuse—and draw out their theoretical and policy implications. The book examines how these forms of deviance were understood historically, and how they came they came to be understood as forms of 'sickness.'

In David Stein's 2001, *Ritalin Is Not The Answer*, he defines ADD. He also discusses behavior modification and other strategies to help children. There is a small chapter that discusses medications to treat ADHD. He uses his own terms, in a book that seems like a parent-hand book. There are common questions and answers, and tips at the end of the book for ways to

stop creating an ADHD child. The book confronts and challenges what has become common practice and teaches parents and educators a behavioral program as an alternative to the use of medication.

Attention-Deficit Hyperactivity Disorder (ADHD) as Fraud, by Fred Baughman Jr. in 2002 discusses trampling human rights in the name of psychiatry. He describes the treatment of diseases that are not real diseases, and how this is unethical. Uses evidence from top ADHD researchers in the country.

The Child Medication Safety Act of 2003 from 2004 verbalizes concerns of consequences of the drugging of children, and the pressure to parents to medicate. *Mandatory Mental Health Screening Threatens Privacy, Parental Rights*, by Wendy McElroy in 2004, is an article about Bush's mental health initiative and what it threatens.

No Child Left Un-medicated, by Phyllis Schlafly in 2004, is an article that describes President Bush's mental health initiative and the danger of mental health screenings for consumers of all ages. It also touches upon how scary it would be for Washington to be in charge of screening all school children.

Parents Against Ritalin, P.A.R., is an international non-profit association of parents who are committed to educating the public about the natural alternatives available for managing ADD/ADHD. The article used is from 2001.

Ritalin: Legally Sanctioned "Speed" by Julian Whitaker in 2004, is an article that outlines the risks of medicine. Gary Null's 2001, *The Drugging of Our Children*, explores the over medicalization and asks if it is even a disease. He discusses the method of diagnosis, or lack thereof. He talks about the national U.S. phenomenon, political agenda, and quick fix for the problem.

The Extent of Drug Therapy for Attention Deficit Hyperactivity Disorder among Children in Public Schools by LeFever et al. from 1999 in the *American Journal of Public Health*, is an article that describes Ritalin as over-prescribed and dangerous. It has some good statistics and quotes from psychiatrist Peter Breggin. It also lists the negative effects of the drug.

There are several documentaries exploring the many sides of this topic. A Dr. Phil episode, on September 28, 2004, describes the ADHD phenomenon, and says children are grossly overmedicated today. Different parents come on the show to talk about personal situations. Dr. Lawless, an “expert” psychologist is at the show to provide his opinion and knowledge.

A Frontline, PBS Special on August 20, 2004, *Medicating Kids*, is a video report on parents, educators and doctors controversial reports on ADD/ADHD. It follows four families, discusses drugs, definitions, and opponents of ADHD.

An NBC Dateline Special on January 18, 2001, *A New Paradigm*, is a report on children medicated for ADD/ADHD and how they feel on the medication. It also discusses the group Children and Adults with Attention Deficit Disorder (CHADD), and parents that attend the meetings.

The plethora of contradicting information on that status of ADD/ADHD show how controversial the “disorder” is, yet more and more children are labeled and medicated for ADD/ADHD. The documentaries exploring this topic were compiled to represent this topic visually.

DISCUSSION

Attention Deficit Disorder (ADD), virtually nonexistent 30 years ago, is a curious condition. For one thing, almost all reported cases occur in the United States. It is estimated that almost five percent of American children are medicated for ADD (with or without hyperactivity), while in England the figure is much lower, about point three percent. The symptoms apparently lessen or disappear in different environments (ADHD Medication Fact Sheet, 2004). This should have people asking, "Hmm... a geographically resistant disease?" It is the only disease commonly diagnosed by those without medical degrees, particularly teachers and counselors. The tests for ADD are entirely subjective - parents and teachers often disagree about symptoms in the same child. Additionally, symptoms of ADD are said to lessen or disappear when people are involved in activities they can control or that they find interesting or engaging (ADHD Medication Fact Sheet, 2004). If ADD "exists" only in controlled, dictatorial environments (such as schools), how is it a mental disorder?

Some say ADD/ADHD and Learning Disorders (LD) in general are a dysfunction of the central nervous system, most specifically the reticular activation system, which results in difficulties of maintaining attention and concentration, learning and memory, as well as involving an inability to process and sort out incoming information or stimulus from both a child's inner (subjective) and outer (objective) worlds. The Vaxa, Solutions for Life website, which advocates natural medicines for the problem, says that it may manifest itself in undue passivity or inattentiveness, or unruly, uncontrollable, aggressive hyperactivity in an affected child (NoMoreADD.com, 2005).

Others say, ADD/ADHD is one of the most common mental disorders that develop in children during their lifetime. A website guiding teachers and parents describes it as developing as a child grows (ADDinschool.com,2005).

Some say ADD/ADHD is a neurologically based disorder. According to a new report released by the Centers for Disease Control and Prevention, approximately 1.6 million elementary school-aged children have been diagnosed with ADHD. In a national survey, the parents of 7 percent of children 6-11 years of age reported ever being told by a doctor or health professional that their child had ADHD (ADDinschool.com, 2005).

The report, "Prevalence of Attention Deficit Disorder and Learning Disability," based on 1997-98 data from CDC's National Health Interview Survey, shows that about one-half of children diagnosed with ADHD have also been identified as having a learning disability (Witmer, 2004).

Children, teens, and even adults with ADD/ADHD often have problems with paying attention to boring work, such as most school work, although they may do well with exciting or stimulating tasks. Many with ADD/ADHD are also impulsive, doing or saying things without

first considering the consequences. People with ADD/ADHD are typically easily bored.

About half of those with ADD are also "hyperactive," meaning that they have high levels of motor activity, classified as ADHD. They like to move around a lot. They often move around from one activity to another, without ever finishing things that they start.

Some say it is a matter of poor self-control, but in the neurological sense rather than the moral sense. They say self-control is a neurological issue. Individuals with ADD ADHD tend to have slower brainwave activity in the front regions of the brain, and they say they are born with the problem (Lawlis, 2004).

ADHD or ADD impacts about two students in every classroom, in every school, across America. Estimates for Attention Deficit Disorder - "ADD" or "ADHD" - range from 5% to 25% of the population. The most accurate number is 5% of the childhood and adolescent population. About 2% of adults are also affected by Attention Deficit Disorder from their childhood (ADDinschool.com, 2005).

In a review of research that has led some to conclude that ADD/ADHD is a neurological condition, Jensen and Conners state: "This section presents substantial evidence that ADHD symptomology has a central nervous system basis (as do ALL normal and abnormal behaviors, thoughts and emotions). By way of caution, such brain-behavior correlations do not constitute proof that ADHD reflects a disordered physiological or anatomic state," (Glock, and Jensen, 1998: p. 54).

With no proof that ADHD is a disease with a confirmatory, physical abnormality, the ADHD "epidemic," has grown from 150,000 in 1970, to five million in 1997. According to the Drug Enforcement Administration, Ritalin production, in the US, rose 700%, between 1990 and 1997 and, the AMA, Council on Scientific Affairs has seen fit to conclude: "...there is little

evidence of widespread over-diagnosis or misdiagnosis of ADHD or of widespread over prescription of methylphenidate” (Baughman, 2002: p.3).

Every patient’s right of informed consent requires a complete, honest portrayal both of the condition to be treated and of the treatment proposed (and how it/they will alter the course of the condition). Lacking either, the informed consent would be incomplete and invalid. Few, if any, questions about ADHD can be answered without an honest answer to the question: “Is ADHD a disease with a confirmatory physical (including chemical) abnormality, or isn’t it?” (Baughman, 2002: p.5)

All physicians, psychiatrists included, complete a course of study of disease pathology. They know, full well, that it is the physician’s first duty, patient-by-patient, to determine whether the patient has an actual disease or has not—the “disease”/ “no disease” determination. We learn that substantial numbers of patients seek help from their physicians for what are “emotional,” “psychological,” or “psychiatric” symptoms, due to the stresses of everyday life. Such patients have no disease per se (ruled out by finding no abnormalities or pathology— nothing objective on physical examination, laboratory testing, x-ray, scanning, etc.) (Null, 2001: p. xvi).

There were few claims by psychiatry in the sixties and seventies of a biologic basis of psychiatric disorders (i.e., that they were “diseases”). Such claims, without scientific evidence, began, in earnest, in the eighties and nineties, with the American Psychiatric Association’s Diagnostic and Statistical Manual-III-R (DSM-III-R) and DSM-IV. “In the 1980s the DSM shifted from over-activity to the inability to pay attention” (Conrad and Schneider, 1992: p.285). ADHD has become psychiatry’s number one, “biologically-based” “disease” (Baughman, 2002).

Author David Stein points out that ADD and ADHD have not been shown to be biologically-based diseases. Stein rightly points out that the only thing a pediatric diagnosis of

attention deficit disorder means is that a child is having problems because he or she isn't paying attention to someone in authority. Stein argues that if a child is distracted or hyperactive, the best solution to the problem is to make changes in the child's home environment. While Stein makes interesting points, his specific recommended changes are difficult to swallow (Stein, 2001).

The CSP program he discusses seems to consist of little more than charts and graphs. Also, since when do we need programs to parent? The experience of many parents of so-called ADD kids is that the best solution is to offer a stable home environment with plenty of parent-child interaction. A program like CSP is only going to get in the way of genuine, nurturing family time (Stein, 2001).

Diseases are natural occurrences in the plant and animal world. Physicians, veterinarians, botanists, and others observe, describe, and validate the pathology, making them diseases. Diseases are not conceptualized in committee or decided upon by consensus, as biological psychiatry would have it (Baughman, 2002).

Some common traits or “causes” of ADD/ADHD, on a parents’ guide for children with ADD/ADHD, are said to be a bad gene, diet, sleep deprivation, herb deficiency, or even red dyes (Pediatricneurology.com, 2005).

One reason to question the status of ADHD and ADD as real diseases has to do with the methods of diagnosis or lack thereof. Usually, before labeling a patient with a condition, doctors do extensive testing to discover abnormalities. They may perform blood tests, x-rays, sonograms, MRI’s, and so on. But no medical tests exist that can determine the presence of ADHD or ADD; therefore, these “maladies” do not fit the criteria for a disease (Baughman, 2002).

Mental health diagnoses are subjective and, to be of value, must be formed by trained

professionals who test and observe subjects over time. The expense and magnitude of screening 58 million people means diagnoses are likely to be made quickly and by poorly trained people.

The criteria for diagnosing mental disabilities such as Attention Deficit Disorder (ADD) is vague and a matter of heated debate within the medical community itself (McElroy, 2004). These children may often be out of control, over-stimulated, under-stimulated, or experience uncontrolled stimulation patterns throughout their sensorial area, exhibiting behavioral patterns which are difficult to explain and which often disrupt an entire household (NoMoreADD.com, 2005).

In the absence of objective medical tests to determine who has attention deficit disorder, doctors use task- and memory- oriented psychological assessments, and behavior ratings scales, on which teachers and parents rate children on questions such as how much they fidget, how well they follow instructions, or whether they are restless or easily distracted. Common Neural Processing & Behavioral Traits of an Attention Deficit Child (ADD/ADHD/LD) are (Pediatricneurology.com, 2005: p.2):

1. Gives up easily on tasks, assignments, and self-interests
- 2: Poor reality testing skills, and avoidant of reason or logic
- 3: Poorly developed skills of integration, interpolation and extrapolation
- 4: Poor skills of attention and concentration, unable to sustain focus of interest
- 5: Difficulties in short term and long term memory acquisition and management
- 6: Difficulty in making up their mind, or making choices without undue anxiety
- 7: Poor planning abilities, unable to follow through consistently or complete tasks
- 8: Difficulty in differentiating between competing, extraneous stimulation
- 9: Easily distracted from tasks, conversations or social interactions
- 10: Often over-stimulated and over-sensitized to their surroundings
- 11: Poor listening skills, often interrupts others, abruptly changes topic
- 12: Overly excitable, reactive and easily perseverating from one situation to another
- 13: Inability to manage emotional responses, temper tantrums

- 14: Easily frustrated, emotionally labile/unstable leading to immediate changeable moods and behavioral inconsistencies
 - 15: Often hyperactive, fidgety, overwhelmed with feelings of restlessness
 - 16: Inability to maintain appropriate social conduct, often disruptive in school
 - 17: Experiences difficulty in following instructions and guidance
 - 18: Impatient, continuing difficulties in delaying gratification
 - 19: Overly demanding, may become self-destructive and aggressive
 - 20: Poor sleep patterns, often not rested, angry or despondent upon rising
- (Pediatricneurology.com, 2005: p.2):

An easy-to-see problem here is that the answers are subjective. What one person views as distractibility, for instance, another may view as natural inquisitiveness. Also, who decides the scale? What is too active or not active enough? Another problem is that some of the questions are based on questionable values or assumptions; for example, one rating scale asks whether the child “actively defies or refuses to comply with adults’ requests”. Another questionnaire also asks whether the child “is always ‘on the go’ or acts as if driven by a motor.” But what about the highly motivated achievers of our society, people who are always on the go because they’re bursting with energy? (Gallagher, 2005: p. 2). These discrepancies have many asking what the causes are for this condition.

Some say ADD/ADHD is a limiting metabolic dysfunction of the reticular activating system, the center of consciousness that coordinates learning and memory, and which normally supplies the appropriate neural connections necessary for smooth information processing and clear, non-stressful attention. When neural building materials are lacking, demand for further connectivity cannot easily be fulfilled, interfering with the efficient processing of information, and frustrating the ADD/ADHD/LD child (Gallagher, 2005).

In other words, neural "hardware" remains in limited production (there's not enough of

it), and supply cannot keep up with the demand (increasing stimulus or "traffic") for new neural connections within the central nervous system. Demands for new learning, memory, and the management of information processing cannot be satisfied, and the insufficient "connections" result in existing neural pathways being repeatedly overworked and over stressed, often resulting in complete gridlock or shutdown so that nothing gets processed thereafter. This, most noticeably, generates frustration, bewilderment and behavioral problems in the Attention Deficit child (Gallagher, 2005).

Some say the Reticular Activating System appears to be intimately involved in the neural mechanisms which produce consciousness and focused attention, receiving impulses from the spinal cord and relaying them to the thalamus, and from there to the cortex, and back again in a feedback loop to the hippocampus/thalamus/ hypothalamus and participating neural structures in order for learning and memory to take place. Without continual excitation of cortical neurons by reticular activation impulses, a child is unconscious and cannot be aroused. When stimulation is enough for consciousness but not for attentiveness, ADD or LD results. If too activated, a child cannot relax or concentrate (and is over-stimulated or hyperactive) often resulting in ADHD (Gallagher, 2005).

Many believe this is a limitation that affects a child's perceptual abilities. Although some say ADD starts in the brain, others say it really involves the entire sensorium (vision, smell, touch, hearing, etc.) as well as the inner world of cognition and emotion. When deprived of the required number of neural connections needed to process the "traffic" smoothly, competition between various stimulus results. Overly competitive stimulation from multiple external and internal sources (too much visual stimulation, too much sound stimulation, too many internal feelings and emotions, etc.) can cause undue frustration, irritation, aggression and anxiety. They

say that when the limited neural network is overly taxed in this regard, it becomes unable to "tune in" or focus on some stimulation, while "tuning out," or "turning down" other stimulation.

This lack of ability to focus on some particular stimulus while attenuating others creates undue "noise" in the perceptual systems within the brain. For the ADD/ADHD child, this perceptual "neural-noise" is so overly noxious and continuous that it appears to be competitively assaultive, crippling any attempt to concentrate on one stimulus while attenuating others. Feelings of helplessness and anxiety are often overwhelming, forcing an ADD/ADD child to look for ways in which to survive the assaultive nature of their world (Kilcarr and Quinn, 1997).

A number of strategies are possible, but two are generally the most common and most easily documented. The first is that of an ADHD child. ADD/ADHD children are hypothesized to have ample supplies of acetylcholine and clear, unobstructed cholinergic pathways, allowing them to actively compete and overwhelm the intrusive messages. Thus, an ADHD child attempts to operate at a "noisier" level (becoming intensely hyperactive), trying to "shout-down" the crowded array of competing stimulation within their brain (Kilcarr and Quinn, 1997).

ADD/ADHD/LD children are hypothesized to have low and unbalanced chemical levels within the neural pathways, making a competitive response more difficult and trying. For both an ADD and LD child, it becomes so "noisy" that it is necessary to shut down all processing of the senses altogether, avoiding and deflecting all stimulation. The incessant cacophony of "neural-noises" produces a powerfully competitive "numbing," almost hypnotic agent, and an ADHD child simply "gives up" to the competitively powerful undifferentiated "white-neural-noise" being generated by their senses because the neural-thresholds of the sensorium have over-fired and can no longer be sustained. Thus, unlike other children, the ADD and LD child simply "shut-down" and "tune-out," producing high theta and/or alpha brain waves (NoMoreADD.com, 2005).

R. Barkley, an ADD internet consultant, explains that for ADHD people, the front part of their brains, “the boss”, doesn’t do a good job of putting on the “brakes”. This means that these people may “have trouble putting brakes on distractions”. Their minds are pulled off the main topic by any competing action. This leads to the “Attention Deficit” of ADHD. If they have trouble sitting still, they are hyperactive (Barkley, 2005).

Teachers, parents, and friends may notice many other problems for those who have ADHD. Often, these problems are not recognized as just being part of ADHD. These people might also be very disorganized. They often don’t get the right assignments home. They may find that other people seem to take forever to eat, shop, or get to the point. Time seems to move so slowly in these settings. Some have trouble with arguing, blaming others, or even lying. Sometimes they have “blow ups” over unimportant things. Much of the information on the subject says that those with ADHD typically need help with organization (Barkley, 2005).

The pressure to have a child whose school attention and behavior are problematic diagnosed and treated with stimulant medication, whether or not diagnostic criteria for ADD/ADHD are met in many cases, is often substantial. The extent to which this phenomenon has become widespread is reflected in state legislation prohibiting school personnel either from recommending or requiring psychotropic or stimulant treatment of students or from imposing penalties for parental refusal to have a child so treated. A new conceptualization of the nature of ADHD and its management is proposed.

The 1998 National Institutes of Health Consensus Development Conference, among its conclusions, stated: “Problems of diagnosis include differentiating this entity from other behavioral problems and determining the appropriate boundary between the normal population and those with ADHD” (Null, 2001: p. xviv).

The DSM itself demonstrates subjectivity and ambiguity in the very classification of ADD/ADHD as a mental disorder, as well as in its diagnostic criteria. The Fourth Edition of the DSM states that: "...it must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder'" (Null, 2001: p.xviv).

None included any evidence of what the cutoff point for any of the categories should be. The subjectivity is also reflected in recent summary comments by psychiatrist Keith Conners, the author of standardized screening questionnaires used in most school systems in the United States. In a condensed review for professionals, Conners includes among that which is unknown about ADD/ADHD, the following: "The exact symptom criteria for defining the syndrome" and "The required symptom severity and level of functional impairment by age and gender" (Glock and Jensen, 1998: p.32).

It is fair to say that definitional and diagnostic precision are lacking. The very nature of ADD/ADHD is unclear. Although widely assumed to stem from a biological or neurological cause, with a significant genetic heritability factor, recent conclusions and statements reveal the lack of evidence to support this assumption.

Reports of differences in various brain structural or functional measures between subjects considered normal and those considered to have ADD/ADHD have led some to believe that these measurable differences establish a central nervous system basis for the syndrome. For several reasons, the reported differences do not justify this conclusion (Glock and Jensen, 1998).

The first flaw in this interpretation is that selection of subjects begs the question of how to establish that the syndrome group has the disorder and that the normal group does not, since (1) there is no test to determine the presence of ADD/ADHD, and (2) the diagnostic criteria are subjective. The behavioral criteria upon which the diagnosis is made have been modified in an

unending series of revisions, as found in DSM II, DSM III, DSM-III-R, and DSM IV (Glock and Jensen, 1998).

Beyond this fundamental flaw, even assuming diagnostic precision for the respective groups being studied, finding a measurable difference in brain structure or function between two groups brings the question of causality. Such measurable differences could represent differences in structure or function as a result of the behaviors defining the syndrome (Glock and Jensen, 1998).

A review of research that has led some to conclude that ADD/ADHD is a neurological condition state the following: “This section presents substantial evidence that ADHD symptomology has a central nervous system basis (as do all normal and abnormal behaviors, thoughts, and emotions). By the way of caution, such brain-behavior correlations do not constitute proof that ADHD reflects a disordered physiological or anatomic state” (Glock and Jensen, 1998: p.6).

Some say that when looked for, ADD/ADHD behaviors are often found among immediate family members and other relatives, leading to a belief that ADD/ADHD is familial, and that this suggests a genetic transmission factor. Research findings have been widely interpreted to support a significant genetic component to the development of ADD/ADHD. “Family and adoption studies suggest a strong genetic basis for ADHD/HKD (hyperkinetic disorder). The twin study methods offer ways to test this hypothesis and estimate heritability of ADHD (Glock and Jensen, 1998: p.8).

Other studies show how unsound research on twins and adoptees has led to the erroneous conclusion that there is a genetic basis for ADHD, and how textbooks typically repeat this

unsupportable conclusion. Psychiatrist Gary Null presents detailed arguments pointing out the flaws in this faulty interpretation of genetic research (Null, 2001).

It is hardly surprising that leading researchers in the field offer inconsistent explanations for the basic nature of ADD/ADHD in their writing. Barkley has offered two good contrasting summary comments about the nature of ADHD in his widely used guide for parents: “I believe the disorder stems from under activity in an area of the brain that, as it matures, provides us with ever-greater means of behavioral inhibition...” (Barkley, 2005: p.2). Later he states, “This means that ADHD should not be considered some grossly abnormal pathological condition- in fact it is a condition not qualitatively or categorically different from normal at all” (Barkley, p.4). William Carey in comments delivered at the 1998 NIH Consensus Conference on ADHD, states: “What is now most often described as ADHD in the United States appears to be a set of normal behavioral variations. This discrepancy leaves the validity of the ADHD construct in doubt” (Carey, 2000: p.1).

Treatments of the “disorder” also lack consistency. They include behavioral therapy and medications. Some advocate natural treatment, such as a raw food diet or flax oil.

Yet, the most common treatment is drugs (NoMoreADD.com, 2005). Attend is one of these drugs, used to treat those diagnoses with ADD/ADHD. Computerized CPT Tests (TOVA: Test Of Variables of Attention) showed that 70% of children and teens using Attend said they had better attention spans and focus on tasks (even boring tasks) , were less impulsive and had more self-control, were more consistent in performance, and processed information faster, and actually had faster reaction times. In fact, those 70% said they experienced improvement near that of the most popular prescription medication for ADD/ADHD, Ritalin, in 30 days (NoMoreADD.com, 2005).

There are many advertisements of things that can be done to help those with ADD/ADHD, for those that believe in the condition. There are several clinical interventions, ranging from medications to non-medication treatments.

The problem becomes further complicated, as in addition to Ritalin explosion, increasing numbers of children are also being prescribed antidepressants, and that these are drugs originally designed and tested for adults, discusses the website *Helping Children, Not Drugging Them* (Shirley's Wellness Café, 2004).

Some argue that these drugs help their child concentrate. There is no question that once drugs are put into the body, they have an effect on the body. But this does not mean that the individual needs the drug. Caffeine may affect an individual and they may seem more awake, but they do not have a caffeine deficiency in the body

Opponents also protest that the safety of these drugs has not been proven. Individual parents and children may decide to take drugs for concentration, but should not be pressured to do so.

Another drawback of ratings questionnaires is that parents and teachers often have a vested interest in the results. Even with the best intentions, they may want a child put on Ritalin, believing that it will help, or that it will make their own lives easier.

As psychologist Thomas Armstrong explains in his book *The Myth of the A.D.D. Child*, in one study, parents, teachers, and physician groups were asked to identify hyperactive children in a sample of five thousand elementary school children. Approximately five percent were considered hyperactive by at least one of the groups, while only one percent was considered hyperactive by all three groups.

In another study using a well-known behavior rating scale, mothers and fathers agreed only about 32 percent of the time on whether a child of theirs was hyperactive, and parent-versus-teacher ratings were even worse: they agreed only about 13 percent of the time (Null, 2001).

Despite the lack of evidence supporting the existence of ADHD and ADD, many parents never think to question the teachers, psychologists, and pediatricians who have labeled their children with these conditions, or to ask about the possible consequences of routine medication.

Those who do express concern are reassured that the experts know best, and they are often sent to a group called Children and Adults with Attention Deficit Disorders (CHADD), a nationwide advocacy group for ADHD/ADD adults and parents of children diagnosed with the disorders. Its messages are that ADHD and ADD are legitimate diseases necessitating medical treatment, prescribed treatments are safe, and that parents refusing to medicate their children are negligent. But there's something that CHADD does not tell its audience, and that is that the group was created and funded by the manufacturer of Tiralin—originally Ciba-Geigy, now Novartis—for the purpose of increasing sales (Null, 2001).

In effect, CHADD is a lobbying group. And it's a powerful one, with more than 500 chapters and 32,000 members. “Most parents are unaware that the group is funded by Novartis”, notes Stein (Null, 2001: p. xv). “I've had many of them come to my talks, only to walk out shaking their heads that they didn't know all this stuff,” Stein says. “They're given very biased information all along, and they become believers that they have children with diseases and that drugs are absolutely necessary, which is sad,” (Null, 2001: p. xvi).

Parents seem to like the information and support they receive at CHADD meetings. Many seem to want an easy solution to control their child, and do not want to think they played a

part in their child's bad behavior. It is much easier for a parent to cope with a biological reason for the hyperactivity, rather take responsibility for their child's behavior.

For those parents who are not as quick to medicate their child, they are often influenced and pressured by teachers and the community and CHADD. After going to the support groups, many seem to feel less resistant to medicate. Psychologist Robert Mendelsohn said, "No one has ever been able to demonstrate that drugs such as Cylert and Ritalin improve the academic performance of the children who take them.... The pupil is drugged to make life easier for his teacher, not to make it better and more productive for the child" (Whitaker, 2004: p.2).

Medicating children for behavioral problems could easily become a form of social control. That is, school authorities could use medication to prevent behavior of which they simply disapproved, such as rebelliousness (McElroy, 2004). The decision to medicate a child should be the parents' decision, with the consultation of the child's doctor. In my opinion, schools and teachers should not play doctor.

Unfortunately, too many families have found themselves pressured to medicate. So many, in fact, that when the Individuals with Disabilities Education Act was rewritten in December 2003, it included a provision that protects parents from being forced to medicate their children as a condition of attending school (McElroy, 2004).

There is tremendous marketability for this "disease". Lobbyists have an interest in continuing the diagnosis and medication of children for ADD/ADHD, as it plays a role in many political agendas. President Bush's mental health initiative is a direct link.

The idea of nationally screening school children for mental health stems from the establishment of the New Freedom Commission on Mental Health in 2002. Its mission is to "promote successful community integration for adults with a serious mental illness and children

with a serious emotional disturbance”. The commission conducted a "comprehensive study of the...health service delivery system," which found mental health problems to be under-diagnosed (McElroy, 2004: p.1).

A 2004 progress report outlines the government's plan to assist those with disabilities, including mental health problems. The government intends to use government agencies and services – such as transportation, housing, and education "to tear down the remaining barriers to full integration [of the disabled] into American life” (Schlafly, 2004: p.1).

The public schools would address "the mental health needs of youth in the education system" through "prevention, early identification, early intervention, and treatment." How early?

Many practical objections have been offered to the mental screening of the 52 million students and the 6 million adults at schools (McElroy, 2004). Political pressure can make schools prone to over-apply social programs, especially when they are connected to the continuation of funding (McElroy, 2004).

On Sept. 9, 2004, the “Ron Paul Amendment” was defeated in the House of Representatives by a vote of 95-315. The Amendment would have prevented the funds sought by an appropriations bill (HR 5006) from being used for the mandatory mental-health screening of Americans, including public schoolchildren (McElroy, 2004). Representative Ron Paul from Texas, a practicing physician for more than 30 years, campaigned against the new program on the grounds that it negates parental rights and would encourage the over-medication of children (McElroy, 2004).

As stated earlier, CHADD is a growing organization to give parents and children tips for dealing with ADD/ADHD. Since CHADD is funded by Novartis, the company that makes Ritalin and many of the drugs prescribed for those with ADD/ADHD, accusations have also been

voiced, specifically, that the program is driven by political-pharmaceutical alliances that benefits drug companies.

Critics point to the fact that the Texas Medication Algorithm Project has been used as a model program. But, according to Allen Jones, an employee of the Pennsylvania Office of the Inspector General, TMAP promotes "a comprehensive national policy to treat mental illness with expensive, patented medications of questionable benefit and deadly side effects, and to force private insurers to pick up more of the tab" (Schlafly, 2004: p.1). The bill has moved onto the Senate, where it will be heard before the end of the year (McElroy, 2004).

This increase in characterizing behavior as disorders can be linked to the pharmaceutical industry. The American Psychiatric Association's Diagnostic and Statistical Manual has grown from 112 mental disorders in its initial, 1952 edition, to 163 in the 1968, DSM-II, to 224 in the 1980, DSM-III; 253 in the 1987, DSM-III-R, and, 374 in the 1994, DSM-IV. That there is more to the explosion of psychiatric "diseases" than scientific naiveté is obvious. To the extent that such research and its dissemination abrogates informed consent and becomes standard practice; is it not fraud? This joint, psychiatric-pharmaceutical industry strategy is obvious (Schlafly, 2004).

An ad placed by "America's Pharmaceutical Research Companies" in Newsweek, October 7, 1996, read: "A chemical that triggers mental illness is now being used to stop it." Here again, is the "big lie." There is no mental illness with a proven chemical abnormality. In their scheme of things, however, scientific facts are less important, by far, than that the public at large becomes a believer in the "chemical imbalance"—chemical "balancer" (pill) view of mental health. When and in which boardroom did they meet to adopt their "disease"—"chemical imbalance"—"pill" model of all human emotional distress? (Schlafly, 2004).

Biopsychiatry's researchers are aware that without proven diseases; the "disease" and "control" groups are both physically normal and indistinguishable. They know from the outset that their research is destined to prove nothing and to remain forever theoretical (Baughman, 2002). Parents should ask "...how can we account for the tendency to seriously compromise research and review standards within a medical discipline known for its commitment to the scientific method?" (Schlafly, 2004: p.1)

Although devoid of science, the invention and revisions of ADHD have enjoyed incredible marketplace success. In 1985 there were 0.57 million stimulant prescriptions (nearly all of them for ADHD), and by 1994 there were 2.87 million. One current estimate (by the DEA) puts the frequency, today, at 5 million (Parents Against Ritalin, 2001).

A young father in Tennessee's son, now 8 years old and on Ritalin, was one of half of his entire kindergarten class referred for a diagnosis of ADHD. Furthermore, the DEA's aggregate production quota for methylphenidate, the main medication with which to treat ADHD, increased 7-fold from 1990-1997. Nonetheless, we have the AMA Council on Scientific Affairs concluding: "there is little evidence of widespread over-diagnosis or misdiagnosis...or of widespread over-prescription of methylphenidate." Are their conclusions justified? (Parents Against Ritalin, 2001: p.2)

Lawsuits filed in Texas, California and New Jersey claim that the booming success of Ritalin is the result of a conspiracy in which the American Psychiatric Association, Novartis Pharmaceutical Corp. and national parents' group CHADD colluded to create the diagnoses of ADD/ADHD. Following the acceptance of ADD/ADHD as medical diagnoses, sales of Ritalin and similar stimulants have skyrocketed, with more than 6 million such prescriptions being

written in 1995, according to the National Institute of Mental Health (Child Medication Safety Act of 2003, 2004).

There is an enormous market for ADD medication. Has there ever been an affliction with a mutual benefit for so many? Parents, teachers, psychiatrists, lobbyists-and of course the pharmaceutical industry- all get a piece of the pie.

The biggest problem with ADD, however, is not its enormous marketability (DeMaria, 2004). The problem is that children diagnosed with ADD/ADHD are the pitiful products of the greed, ignorance, apathy and/or total lack of misunderstanding by the medical community, pharmaceutical companies, food manufacturers and parents (DeMaria, 2004). Not only are the pharmaceutical companies making money from this, but there is an increasing cost to society in insurance (Baughman, 2002).

So why is medication for ADD/ADHD so popular? For some parents and teachers it is considered the easy answer. It explains the behavior without assigning blame. Currently, there is an increasing reliance on personal unaccountability for behavior.

The heart of this crisis, and that of over-medicating in general, is the exceeding reliance on personal unaccountability and negativity toward our bodies and minds (Baughman, 2002). The medication may be considered the easy fix. Popping a pill may also be less expensive than counseling, and less difficult than solving the problem.

There are better ways to make schools work, such as appropriate therapy for troubled children, but these approaches are more difficult, and more expensive. The school district may have a vested interest in medication as a quick, less costly fix, although this may not be what's best for a particular child.

Who would want to spend years of their life, and chunks of their income, conversing with

a therapist when they could just pop a pill? The reliance on medication to treat mental illness - ADD included - reflects directly on the way we regard our health. By treating our unhappiness or hyperactivity with a pill, we are regarding our condition as an infection not unlike the flu. It's just there - we did nothing to bring it on and thus we have no responsibility to figure out why it's there. We speak negatively of mental illness - we have disorders, deviations and imbalances that must be subdued. We swallow pills that will destroy the problem. Medicating children for ADD sends the same negative message to those who are just beginning to learn how to take charge of their own lives and develop the requisite life coping skills. By treating these problems with therapy, however, we imply that our unhappiness stems from something we did that made us unhappy. We take charge of our own future and strive to make positive changes.

Psychiatrist Peter Breggin, who specializes in the contradictions in mental illness said, "The drugging of children has gotten so out of hand that America is waking up to this. This is a national catastrophe. I'm seeing children who are normal who are on five psychiatric drugs" (LeFever, et al., 1998: p. 4).

The side effects of these drugs are continuous and many alarming. The side effects of the most popular drug used for ADD/ADHD, Ritalin, include insomnia, loss of appetite, and weight loss (Parents Against Ritalin, 2001).

Ritalin is the number one prescription drug for children with ADD/ADHD. This drug has such tremendous potential for abuse that it is classified as a controlled substance by the Drug Enforcement Agency. Ritalin is an amphetamine, which some compare to "speed", with its' lengthy list of side effects, including nervousness, insomnia, nausea, abdominal pain, loss of appetite, dizziness, palpitations, headaches, irregular heart rhythms, and psychic dependence, in short, addiction (Whitaker, 2004).

“Ritalin is a drug that has a more potent effect on the brain than cocaine. And we’re supposed to be a country that eschews the use of such mind-altering substances, certainly for children” (Null, 2001: p. xviii). Ritalin has also recently been linked to the possibility of cancer. Researchers from Department of Epidemiology and Department of Preventative Medicine at the University of Texas studied 12 children who were taking prescribed doses of Ritalin. The results show increase in chromosomal aberrations, which are often linked with increased cancer risk. Adderall XR, a common drug prescribed for ADD/ADHD, has also been recalled recently (Parents Against Ritalin, 2001).

Many of the psychiatric medications administered to children have been only approved for and tested on adults. The long-term effect on developing children has yet to be determined. The known side effects can be severe. Indeed, at least two deaths have been attributed to prescribing Ritalin to children (McElroy, 2004).

The long term effects are even more frightening, as most are unknown. Many include anti-social behavior, self abuse, and “mental illness” (Whitaker, 2004). In fact, Ritalin's appeal to drug users and its potential for abuse are so high that US House Judiciary Chair Henry Hyde (R-IL) recently filed a request with the General Accounting Office to conduct an investigation of Ritalin abuse in public schools (Whitaker, 2004).

A major segment of NBC Dateline (1/18/01) reported widespread abuse of Ritalin among students, according to investigative reporters interviewing students at several major colleges in different areas of the country (A New Paradigm [documentary], 2001). A Dr. Phil episode in 2004 and a Frontline documentary continued to expose the problem (Medicating Kids, 2004). Although some of the media coverage of ADD/ADHD is challenging the modern paradigm, much of the coverage is seen as advertising the drugs.

Some believe that the effects of the drugs contain too many uncertainties and possibilities of abuse (McElroy, 2004). Beyond the physical side effects, the known and unknown psychological side effects are also frightening.

The trend to classify children as psychologically abnormal is especially alarming, as labels tend to remain with children throughout their school careers and beyond, resulting in lowered self-esteem and limited options. They are frequently told they have a genetic malfunction and unaccountable for their own actions (Stein, 2001). The alarming message sent to these medicated children is that they are diseased troublemakers and flawed.

According to Stein, “ADD is a stigma, and probably an unnecessary stigma to have to live with... Current treatment programs are designed with the idea that (the ADD child is) diseased and handicapped. They treat the child in such a way as to help him, coax him, warn him, assist him excessively, post rules, and sit with him when he does homework.” Stein says the result is that children labeled as having ADD begin to develop four types of dependencies (Stein, 2001: p.62):

1. Task dependency- the belief that they cannot initiate and complete a task without someone helping them;
2. Cognitive behavioral dependency- a constant need to be reminded about how to behave in different environments
3. Emotional dependency- the belief that they have to have someone help them all the time
4. Medication dependency- the belief that they can't function unless they take the drugs, even if a physical dependency of the drug does not exist (Stein, 2001: p.62)

Such dependencies are counterproductive to normal, healthy development, Stein points out. Children should be encouraged to become confident and independent, but limiting beliefs

about the capabilities of “diseased” children can keep them handicapped well into their adult years (Parents Against Ritalin, 2001). .

The message that is sent to children is that our society values conformity, and devalues creativity. Our children are also getting the message that they need a pill to function in this society (Parents Against Ritalin, 2001).

Leaving potentially disruptive children unmedicated can make a teacher's job more difficult. It can affect the other students. But doesn't it send a more positive message to regard these children as healthy, creative individuals rather than diseased troublemakers who need a pill to function?

The Social Construction of ADD/ADHD

In my opinion, pills have become crutches - excuses for us to ignore the sources of our troubles, and thanks to the successful marketing of ADD/ADHD as a legitimate disorder, we have set up a generation of children with the means to regard themselves as flawed and unaccountable for their own actions.

Leaving aside the many problems of a working definition, and the ambiguity and subjectivity of diagnosis already discusses, there appears to be a trend to increasingly younger ages at which children are being diagnosed and treated. This raises further concerns about potential detrimental effects of stimulant medication, especially when treatment is continued for prolonged periods of time, in many cases for years or even decades (A New Paradigm, 2001). By labeling at a child as ADD/ADHD, the real problem, if there is one, is not addressed, and only the symptoms of the problems are alleviated with medication. Armstrong said "Thousands of

studies tell us what children with ADHD can't do, but few tell us what they can do" (Child Medication Safety Act of 2003, 2004: p.2).

The child's "problem" may not be that he or she is diseased. The ADD/ADHD child may simply be not interested in school, or learn differently than the conventional child. There is also a strong positive relationship between parenting practices, and the behavior of the child. What is acceptable behavior at home may not be acceptable in the classroom.

Often, in today's busy way of life, children may be raised by the television. This lack of attention at home, and the rapid movement and excitement on television, may spill over into the child's behavior.

If a parent was too permissive with the child, they may lack control of the child's behavior. Often the "ADD/ADHD" child's lifestyle should be assessed. If their lifestyle is chaotic, their behavior may be as well (DeMaria, R, 2004). The child may be starved for affection, attention, or important nutrients that are not available in some modern fast-food diets (Child Medication Safety Act of 2003, 2004).

The ADD/ADHD child may learn differently than the typical child. Look at the historical figures who transformed society, and we will find that many of them were behavior problems or hyperactive as children: Thomas Edison, Winston Churchill, Pablo Picasso, Charles Darwin, Florence Nightingale, Friedrich Nietzsche (Child Medication Safety Act of 2003, 2004). "As educators, we can make a big difference in the lives of these students if we stop getting bogged down in their deficits and start highlighting their strengths" said Armstrong (Child Medication Safety Act of 2003, 2004: p.3).

It is important to remember that hyperactivity may not be a negative trait. "The child may be building on their interests, learning styles, and many talents. Remember that a hyperactive

child is an active child,” Armstrong continued (Child Medication Safety Act of 2003, 2004: p.1). Boredom may also be a positive and necessary experience for a child. Not everything in life is exciting, and a part of growth is learning that and getting through it.

Many parents whose children have been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) are being pressured into drugging their child by a school psychologist, social worker, teacher, or principle (Child Medication Safety Act of 2003, 2004). They are even threatened further with the label of a child abuser, if they choose not to medicate.

In New Mexico if a parent takes their child of medication for ADD/ADHD, such as Ritalin, the parent could be arrested for abuse and neglect (Child Medication Safety Act of 2003, 2004). Paul wrote, "Psychotropic drugs are increasingly prescribed for children who show nothing more than children's typical rambunctious behavior. As mentioned, many children have suffered harmful effects from these drugs. Yet some parents have even been charged with child abuse for refusing to drug their children. The federal government should not promote national mental-health screening programs that will force the use of these psychotropic drugs such as Ritalin" (McElroy, 2004: p.1).

The screenings may be used to force parents to put their children on psychiatric medication. Some parents who have refused to do so under current policies have been threatened or charged with "child abuse" for no other reason than their refusal.

One parent who successfully challenged a court order regarding forced medication is Nestor Sosa, a divorced father, who, upon arriving home one day, was handed a court order to give his son Ritalin. This was how Sosa learned that his son had been given psychological tests, found to have ADHD, and put on medication. All this had occurred without Sosa's knowledge or consent; therefore, it was a violation of his joint custody agreement, he reasoned, and he

would challenge the order. In the end, the doctor had to admit that there was no validity of the diagnosis. Sosa concludes, “This whole thing is a pure scam,” (Null, 2001: p. xvii) and advises other parents fighting the system to enter the arena well informed. Parents must take an active stance, and can do so in the following ways (Null, 2001: p. xvii):

1. Document everything. Write down who said what and when they said it.
2. Ask the school to tell you, in writing, how they diagnosed ADD, the qualifications of the teachers making the diagnosis, and what objective medical tests were used to confirm the diagnosis. Have them sign the documents under penalty of law.
3. Let the school know that under federal law (United States Code Title 20, Section 1232H) you are allowed to obtain all records and that you are able to refuse any participation by your child in psychological surveys, analysis, and evaluations.
4. Obtain all medical records from any doctor prescribing drugs. Have the physician tell you (also in writing) how he or she confirms an abnormality in a child and how the abnormality justifies the use of a toxic, controlled substance such as Ritalin. Make sure that any tests given were made prior to exposure to any psychotropic medication, so that what is diagnosed is not an iatrogenic condition (a condition caused by medical treatment). You are entitled to all medical records and should obtain the entire set.
5. If Child Services gets involved, have them provide you with the tests they used to confirm that your child has a disease. If they respond with defamatory remarks about your character- for example, they say you are unfit parents for not giving your child a controlled substance- you have the right to sue them for slander.
6. If the tests you have requested are not given to you by your court date, ask the court to produce the tests. Inform the court that without a valid test, you and your child have been deprived of proper informed consent. Let the court know how upset you are that your rights have been violated. (Null, 2001: p. xvii)

Critics also raise matters of principle. First and foremost is the question of parental rights. It is not clear what rights, if any, parents preserve over the medical treatment of their children.

Will they be threatened with the removal of their child if they refuse to place a son or daughter on Ritalin? (LeFever, et al., 1999).

Will children who resist medication be expelled from a school that is supported by their parents' taxes? If so, the government seems to be telling parents that education is a privilege for which parents must not only pay but for which they must also surrender medical control over their children (LeFever, et al., 1999).

And what about medical privacy rights? It defies credibility that psychiatric records on tens of millions of school children would be covered by anything resembling patient-doctor confidentiality. Public school records that include intimate details of medical history may well follow children into adulthood (McElroy, 2004).

There are better ways to make schools work, such as appropriate therapy for troubled children, custom-tailored education plans, and small class sizes. It is time for a new approach. But these approaches are more difficult, and more expensive. Therefore, the school district may have a vested interest in medication as a quick, less costly fix, although this may not be what's best for a particular child. Dr. Stein says, "The drugs blunt their behavior. They don't act out in class, and they sit their quietly. The difficulty is that children learn nothing from a drug" (Null, 2001: p. xxv).

It is psychologist Jeffrey Schaler's view that ADHD and ADD are not pathological diseases, but socially constructed labels that members of the mental health profession use to control children, to homogenize people, and, basically, to create a nation of zombies. These conditions are not listed in standard textbooks on pathology, Schaler points out. What we need to do, he says, "is teach parents to just say no to psychiatrists who advocate drugging children in the name of treating a mythical disease" (Null, 2001: p. xviii).

Schaler says, in short, that psychiatry is pathologizing behavior. But behavior is not the same thing as disease, because behavior is made up of activities that people choose to engage in for reasons that are important to them, which is unlike actual diseases that do not vary by culture.

CONCLUSION

It is ironic that a society that parades billboards professing "Say No To Drugs" is the same society that is forcing parents to subject their children to psychotropic drugs or lose custody of them. This shows that in today's society outsiders have more jurisdictions over a child than the parents (Child Medication Safety Act of 2003, 2004).

The trend toward psychotropic overmedication is something that affects all age groups in our society, but children are particularly victimized in two respects. First, children were not included in the pre-approval trials for many of these drugs, and because their brains are smaller and still developing, they may be more vulnerable to the side effects. Second, and most importantly, they cannot speak for themselves or are not given the opportunity to. Since parents are the best advocates for children, it is time for parents to come together and fight this horrific war against the drugging of our children, America's future, in the name of treatment for a mythological disease.

In conclusion, there are too many questions to this recent, mostly American, phenomenon on medicating children for behavior in the name of mental illness. The entirely subjective tests and vague causes and cures do not support the existence of ADD/ADHD. The "disorder" is mutually beneficial for parents, teachers, lobbyists, and pharmaceutical companies. It is a

convenient myth to believe that problems can be fixed with a pill and individuals are unaccountable for their actions, and it is less expensive than counseling. Unfortunately, the physical side effects of the drugs and the psychological consequences of believing this myth and labeling individuals, as shown by this paper and video compilation, outweigh the convenience. ADD/ADHD is a dangerous diagnosis.

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