Introduction

Family Experiences of ADHD

Attention-deficit/hyperactivity disorder (ADHD) is a complex psychiatric dysfunction that affects not only the individual who experiences the symptoms but also the individual's broader intergenerational family system. While the etiology of ADHD is based on bioneurological factors, it does not exist in a vacuum. Each family system must make accommodations to the symptomatic ADHD individual in order to maintain the family's stability and equilibrium. The necessary accommodations by the family system are often extensive and affect all family members *and* roles: parents/spouses, siblings, and grandparents. The adjustments that each family attempts to maintain, as well as the stresses and frustrations that are experienced, are present throughout the multiple subsystems and across several generations.

Given the genetic characteristics of ADHD, its diagnosis in a child becomes a "red flag" that other family members—a sibling, parent, cousin, uncle, grandfather—may also have ADHD. In families in which there are multiple ADHD members, the complexity of systemic dynamics and the need for accommodations increase exponentially.

ADHD is not contained within the boundaries of a family system. The symptomatic member experiences difficulties throughout her or his life in educational, social, and occupational endeavors. There is no cure for ADHD—but there *are* significant interventions that can normalize the ADHD individual's life experiences as well as stabilize the family system. *We believe that working with the ADHD individual in the context of her or his immediate, and even intergenerational, family system is one of the most effective clinical interventions available.*

As a psychiatric disorder, ADHD is complex and difficult to evaluate and diagnosis. However, there are effective protocols for the evaluation. We believe that conducting the evaluation—for children,

adolescents, or adults—in the context of each individual's family milieu offers one of the most effective means of assessing the impact of ADHD on both the individual member (and) the overall family system. Before we explore the more technical and clinical aspects of ADHD, we will share some stories of ADHD individuals that illustrate the complexity of their struggles and the responses of their families.

Eight-year-old David slumped in his chair in the therapy session, crying. His parents had spent the last 10 minutes venting their frustration and anger at him because they believe that he is not trying in school. The school year had barely begun and David's teacher had already called his parents several times to report his failures and misdeeds. The parents' nightmare had returned. Last May the teacher and principal wanted David to repeat the second grade. His teacher had warned that he was not progressing as expected and that he was not getting along with the other students.

The parents had spent the summer investigating private schools and had decided to enroll David in a small church-sponsored elementary school was expensive and a 45-minute drive from their home. They expected improvements in David's learning level and conduct because there were only 16 students in the class and the teacher was a 20-year veteran. However, the new teacher voiced a hefty list of concerns: David was not motivated, was not completing his work, was not paying attention; would interrupt her for minor requests (such as asking for a new pencil after he had lost his own), and would interrupt the class with questions not related to the subject.

By the fourth week of school David had already been absent 10 days due to illnesses. He had been referred to the therapist (CAE) by his pediatrician, who had found no medical reasons for him to miss school. The parents believed that David was lying and that, after all they had gone through to find him a better school, he did not appreciate their efforts. They had struggled with applying many disciplinary techniques that they had read about, but to no avail—David did not improve.

David was a bright boy. When he was interviewed without his parents present, he was engaging and articulate, though somewhat sad because of his frustrations in school. He told the therapist that he loved to play on the computer and that he had taught himself how to create animated figures. He knew how to "surf" the Internet, log on to chat rooms and converse like an adult, and play at computer games designed for adults. He reported that he had been in "big" trouble during the second grade because he had installed a new screensaver and programed the school's computer to print a greeting to his teacher. Though the greeting was mildly offensive, he believed it would be a pleasant surprise for her. He said that he did not like to read books but that he was following real-life adventure reports on several websites, as well as read-

ing an encyclopedia that his father had installed on the computer—he was up to the "G's" and explained to the therapist how a gyroscope worked.

His parents had recently taken away his computer privileges as a punishment for his problems in school. They had asked the therapist, "How can he sit in front of that computer 5 hours a day and yet be unable to finish his schoolwork or pay attention in class?" In the first family session the therapist asked David to explain to his parents what he had told him about his struggles in school. At first David resisted talking about his problems and said he worried that his parents would only scold him. However, with a little prodding by the therapist, he finally tried to explain to his parents, tearfully, "I have files in my head that I can see, but sometimes I just can't keep the right information in each one."

Later in this parent–child session the therapist explained to the parents that while David was very bright and, of course, should be doing much better in school, there was a possibility that he might have ADHD. The parents looked at one another in amazement and disbelief. Both parents are high achievers. David's mother has a master's degree in education and his father operates a very successful small business with dozens of employees. David was their only child. The parents' immediate response was to deny the possibility of ADHD. By the end of the session the mother began to recognize the symptoms but became tearful about David's future. However, the father was more reflective and admitted that he has never liked to read either. In fact, he reported that he experienced difficulties early in school in both reading and writing. He wife looked at him in amazement because he had never shared this information with her, fearing that she might not think as highly of him and his success. Though he had become an excellent draftsman and owned his own company now, he had always wanted to be an architect. He had given up that dream after just 1 year of struggling in college. After further evaluation and testing, David was diagnosed with ADHD, combined type. His tests indicated that he has a Full-Scale IQ on the Wechsler Intelligence Scale for Children (WISC) of 132. Several weeks after this family session David's father called the therapist and asked to be evaluated for ADHD too.

This is a common story about the discovery of ADHD in a family. Sometimes the symptoms are recognized early, even in a toddler whose behaviors are difficult and unmanageable (hyperactive–impulsive). However, the ADHD symptoms can be subtle (inattentive type) and may not be identified until a child has struggled for several years in school, like David. Unfortunately, for many individuals who are never diagnosed, the symptoms persist throughout their school years and into their adult lives, affecting their marriages, their parenting, and their occupations.

The presence of ADHD in a family member can affect the entire

family's everyday interactions and behaviors. At times its presence can profoundly affect the parents' marriage.

A month after David was diagnosed with ADHD, his father called the therapist and asked if he and his wife could be seen together, without David. They reported that their relationship had been in chaos since the initial diagnosis. The mother was having difficulty emotionally accepting David's ADHD, even though intellectually she had reviewed the tests and recognized the effectiveness of the stimulant medication on David's behavior in school. She acknowledged tearfully that she saw David as "damaged" and she blamed her husband (genetically) for this. As a child, she had lost a younger brother in a car accident, and these issues with David were causing her to relive many of those painful memories. Unfortunately, the father's early fears about revealing his own school struggles were proving to be realistic, since his wife now saw him as "damaged" and had become critical of his relinquishment of a career in architecture.

An ADHD child's impulsive and hyperactive behaviors can have similar detrimental effects on parents' confidence in their management skills.

Six-year-old Billy had just entered the first grade. His parents were reviewing their difficulties with him in their initial meeting with the therapist (SVE). They described him as playful, but unlike their two older children, he had never enjoyed being cuddled. He had crawled and walked early but, after that, they could no longer contain him. He got into everything and never listened to them. At 3 years of age he was taken to an emergency room after receiving a severe gash on his arm—he had tried to climb the front of a bookcase and had pulled it over on himself, breaking a glass vase. At 4 years of age he was again taken to an emergency room after falling nearly 5 feet off a ladder that was propped against their house. The father had been working on the roof and had left the ladder in place while he went to the hardware store for supplies. They learned later that the boy had actually spent some time on the roof while the father was gone and that he fell while climbing down!

Billy had been asked to leave six different preschool programs over the previous 2 years. His teachers claimed that he was often rough and bullying with the other children. Other parents had complained about him and threatened to withdraw their children if Billy's conduct did not improve.

The parents acknowledged that they had fought with one another about how to handle Billy for several years. The father wanted to be tougher and more punitive with Billy "to get his attention," while the mother "kept reading books" and wanted to "reason with him." They indicated reported similar difficulties with their older children and they could not understand what they were doing wrong. For several years they had blamed one another for Billy's

struggles. Soon their older children complained because the parents spent all their time and energy arguing about Billy.

Both parents questioned not only their functioning but even whether they should have given birth to this third child. They relived this decision many times in arguments with one another. They also acknowledged that they had stopped going out together, as well as with friends, because they continually argued about Billy. They had decided against a family vacation the prior summer because the last trip with Billy was "so horrible." They had not made love for 9 months.

Billy was diagnosed with ADHD, combined type. After several months of parent training and family therapy, Billy's behavior was improving and the parents felt more in control of their family. However, they remained in marital therapy for another 6 weeks to repair the damage to their relationship caused by the many years of their parental struggles and loss of intimacy.

The diagnosis of ADHD in a child can also cause serious sibling rivalries and confrontations in the family.

Eleven-year-old Bryan had been diagnosed with ADHD in the third grade. He was now in the fifth grade and had been medicated with a stimulant at the time of his referral. He had been quite hyperactive and impulsive, displaying reactive behaviors toward his two older siblings, teachers, and peers, and breaking objects and hitting walls. His behavior was better in school due, in part, to a smaller and well-structured classroom setting with a teacher who was effective in keeping him focused. However, his reactive behaviors still erupted periodically at home. Just before he was referred for therapy, he had become angry at his 15-year-old sister who had refused to let him enter her room. The parents were still at work. The sister felt he had been "acting wild" all afternoon and went into her room and closed the door. After 30 minutes of arguing with him to leave her alone, she locked her door and turned up her music so she could not hear him. Bryan returned with a garden pick and proceeded to smash it through her door several times. The sister was frightened and called her mother from the phone in her room. Before the mother could get home, Bryan had ripped two large holes in the sister's bedroom door. He was hiding in the back of the family's yard when the mother returned home.

In the family sessions with everyone present, the two older siblings spoke of their years of frustration and anger not only toward Bryan but toward their parents. They felt Bryan was "screwed up," and they could not understand why he received so much attention from their parents and why their parents could never control him. After the recent incident, the sister talked of wanting to live with a friend. She said that she no longer respected her parents because they never spent time with her and they could not control Bryan. She also said

that when she left home, she never wanted to see Bryan again and that she would not be sad if he died.

The ADHD symptoms can intrude dramatically into a family's experience, affecting not only the child but all members of the family, as well as intergenerational relationships.

Fourteen-year-old Susan had just completed her first semester as a freshman in high school. In middle school she had received grades of C's and a few B's. Her older brother, who was more interested in sports in high school, received mostly B's. Her younger sister, who was in the sixth grade, received all A's. Susan's parents, particularly her mother, had begun to put more pressure on her to improve her grades as she began her first year of high school. However, after her first semester as a freshman, she received two F's, two D's, and three C's. Her parents were concerned and frustrated; the teachers were telling them that Susan was not reading up to grade level, she was not completing or turning in her homework, and she never seemed to be able to complete examinations.

Susan's maternal grandparents lived nearby and had a close relationship with her. However, they had told her that the money they had saved for her to go to college would be given to her sister, since she was doing so poorly. They said that her sister was the "only one in the family who cared about grades." Susan had also overheard several arguments between her mother and grandmother about her grades and had seen her mother crying afterward.

Susan's parents reported to the therapist (SVE) that they had never pushed any of their children as much as they had tried to push Susan the past year. In fact, they both reflected that they had vowed not to push their children because they had been pushed so much by their own parents. Susan's mother was particularly distraught because her mother was now accusing her of being a "bad parent" as a result of her granddaughter's failures in school. The grandparents had told her that because she had not pushed Susan, she "would never amount to anything"—and they certainly hoped she did not let the same thing happen to Mary, the youngest child. The mother was avoiding telephone calls and visits with her mother, and her husband had become angry over his in-laws' intrusions. They acknowledged that this conflict with the grandparents over Susan's grades had created the most stress between the two of them that they had ever experienced in their marriage. The husband said that he had become so angry at the grandparents and his wife, for not keeping them out of their family's life, that he had begun thinking of divorce.

The presence of ADHD in adults creates complicated layers of family dynamics and interactions, as well as associated comorbid symptoms, which can be difficult and challenging for the clinician.

In just 6 months in his practice one of the authors (CAE) had identified three adult males—ages 32 to 45—who had each been referred for therapy by their wives. These men displayed symptoms that included anger, aggression (occasional violence toward persons and property by two of the men), irritability, negativity, reactivity, moodiness, and ongoing conflict in their marriages and with their children. All three of the wives reported that their husbands displayed frequent periods of emotional unavailability toward them and their children, as well as erratic and impatient parenting behaviors.

Two of these men had been previously diagnosed with a bipolar disorder. The diagnoses had been made at 15 and 28 years of age. All of the men had been in therapy, off and on, since their diagnosis and had continued to consult with psychiatrists to monitor their medications, which included lithium, and later Depakote, as well as a variety of antidepressants. One had stayed with the original diagnosing psychiatrist while the others had changed psychiatrists, often at the urging of their spouses or friends, to seek more effective treatment. None of these men, and only one of the wives, had ever heard of ADHD. The wife who recognized the disorder reported having read some literature about it several years ago because her son's sixth grade teacher had mentioned that he might have it, but there had been no follow-up.

Two of the men were seen initially in an individual session for evaluation. Each expressed regret over his anger and occasional violence in his family and also stated that, despite a full array of pharmacological interventions and some therapy, the problem behaviors had never improved. When they were interviewed in the next session with their wives, it was learned that during the previous years of treatment and medication reviews, only twice was one of the wives interviewed by a psychiatrist. All three wives stated that they had often called their husband's psychiatrists or therapists, particularly following dramatic and unpleasant confrontations and erratic behaviors, and felt that their requests, and even pleas, for help had been rebuffed or ignored.

The joint interviews with the wives revealed a number of clinical signals—red flags—regarding the accuracy of the bipolar diagnoses and the potential for underlying (implicit) adult ADHD. After listening to the wives' reports of frustration, anger, and helpless feelings, the therapist began to evaluate the broader picture of both the husbands' early social and educational histories and their marital and family experiences.

The histories of all three men were quite similar: poor school performances (one never competed high school, one later completed his GED); frequent fights beginning as early as the fifth grade and continuing into high school (one had several assault charges as an adult, two reported slapping their wives, one reported hitting his children); drug use (two had serious problems with alcohol beginning in high school, one had serious periods of alcohol abuse as an adult) poor work histories (two of the men); and an inordinate number of traffic violations and accidents. All reported poor impulse control, which created problems in their communication and spending habits.

The wives confirmed even broader patterns of impulsivity, impatience, reactivity, moodiness, failure to start or complete projects, failure to remember conversations, failure to follow through with instructions, preoccupation with television and channel surfing, and a disinterest in playing with, or reading to, their children. While the wives reported manic-like patterns in some of these symptoms, only one identified significant periods of moodiness and depression. The information obtained in these marital interviews suggested that all three of these men had been misdiagnosed with bipolar disorders. It was also clear that subsequent clinicians and psychiatrists simply continued to accept this diagnosis without considering its accuracy or the compelling differential symptoms. This error was further exacerbated by subsequent clinicians' failure to interview the spouses and to gather data regarding the bigger picture of the individual's family milieu.

Since two of the men stated at the onset of their interviews that they had been diagnosed with bipolar disorder, the therapist was not expecting underlying ADHD issues. The early red flag was the men's indication that they had "done everything possible," "taken every pill" they had been given, "tried to control" themselves better at home, and nothing had improved. In fact, two of the men indicated clearly that they had never experienced beneficial effects from the variety of medications they had taken over the years.

The warning signals of ADHD may have been missed if the marital interviews had not further explored the behavioral patterns and symptomatology. As part of the ensuing evaluation, two telephone interviews—the first with one of the men's father, his only living parent; and the second with the other man's parents and a brother—were conducted. These family-of-origin consultations, as we will discuss in later chapters, provided important childhood observations and histories that only parents could make available. The information gained from these interviews corroborated the ADHD diagnoses. The interaction with extended family members also revealed that one of the men's fathers and potentially two siblings had displayed ADHD symptoms. It was also learned in subsequent interviews that two of the three families had children with ADHD symptoms.

Following the preliminary ADHD diagnoses, the three men were seen by two psychiatric colleagues regarding the diagnostic issues and possible changes in their medications. All three men were placed on stimulant medications and the one who had displayed some depression was continued on a previously prescribed antidepressant. All three wives, within days, reported dramatic changes in their husbands. Most notably, they reported that their husbands' unrelenting intensity had subsided. One wife called the therapist within 3 days to say that she was amazed that her husband was able to sit still for more than 5 minutes and actually carry on a conversation with her. Another wife called, tearfully reporting that she had come home from work the previous day to find her husband playing quietly on the floor with their 7-year-old daughter. She said this was the first time she had ever seen him do that.

They participated in family therapy sessions that included their children. Those children suspected of also having ADHD were evaluated and a treatment plan was developed for them. Subsequent marital sessions were helpful in repairing the damage of distrust, hurt, and lost intimacy. The family sessions were instrumental in helping the children understand their fathers' disorders and their previous behaviors, as well as a beginning step toward repairing parent–child trust.

As we have illustrated in these case overviews, we believe it is essential that both the evaluation and the resulting treatment plan occur in the context of the ADHD individual's family milieu. To accomplish this, the therapist must learn to listen to the struggles of *all* the family members, respecting their observations as well as their own unique resources for change. We have been in clinical practice, for nearly 25 years and have learned that all families, no matter how dysfunctional they may appear, have inherent resources that can be mobilized to affect lasting change. These resources may have been camouflaged or buried for years under conflict, but the skilled family therapist learns to sort through these subterfuges to reveal the issues and create healthier interactional experiences.

As a result of our experience in working with families, we have always focused on the child's symptomatology as a window into the clinical dynamics of the entire family. Even before the development of the ADHD diagnosis, we were working with families to contain and manage the hyperactive behaviors of a single child and the resulting impact on siblings and the marital relationship. We have learned much from the ADHD families with whom we have worked, and, in our experience have found *family therapy to be the most effective treatment of choice.* In the following chapters we describe our methods of evaluating and treating ADHD individuals—children, adolescents, and adults—in the contexts of their family systems.

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