

# CHALLENGING CASE: FAMILY RELATIONSHIPS AND ISSUES

## ADHD, Divorce, and Parental Disagreement About the Diagnosis and Treatment\*

### CASE

Steven Davis, the divorced father of Sara Davis, aged 7 years, called Dr. Francis, Sara's pediatrician, with a sense of distress and urgency as he asked for "another opinion" about his daughter's attention-deficit hyperactivity disorder (ADHD). Mr. Davis asked if he could first speak to the doctor without Sara present. Dr. Francis agreed, and at a first meeting Mr. Davis explained that his ex-wife, now remarried as Carol Henry, unilaterally took Sara for an evaluation by a psychologist associated with a large tertiary care university medical center. According to Mr. Davis, he was never contacted by the psychologist, nor did he know of the evaluation at the time. The psychologist determined that Sara had ADHD and recommended stimulant medication as part of the treatment plan.

Mr. Davis, who had joint legal and physical custody of Sara and her older brother, did not experience any behavior problems with Sara on the 3.5 days per week she spent with him. He acknowledged she required immediate response and firm discipline, but she generally behaved quite well at his home. He believed her mother's environment was more chaotic, with looser and inconsistent standards of discipline. He was aware of some behavior problems at school, but believed they were minor and were managed effectively by Sara's teacher. He was not willing to permit his daughter to take methylphenidate, but he also feared that Sara's mother had a secret agenda. He believed that Sara's mother and stepfather intended to soon leave the state and wished to take both children with them. He believed that his opposition to the use of medication would be used as grounds for the judge to award physical custody of the children to the mother and allow them to leave the state together.

The pediatrician asked Mr. Davis if the children's mother had been informed about his desire for another opinion. Mr. Davis said that he had asked his ex-wife if she would join him for this visit with the pediatrician. Mrs. Henry refused, declaring that Sara had received an excellent evaluation from an expert at the university and that another evaluation was unnecessary and would stress Sara needlessly. Dr. Francis telephoned Mrs. Henry to see whether she could directly engage the mother. Mrs. Henry initially agreed to an office visit and then canceled the appointment. Dr. Francis then received a letter (cop-

ied to Mr. Davis) from Mrs. Henry's attorney suggesting that any further evaluation should wait until the psychologist's written report of the evaluation is received.

Two weeks later, Dr. Francis received the evaluation. The psychologist had performed a complete psychometric assessment that indicated the absence of any learning problems. There were minimal signs of impulsivity in the office setting. The evaluator had relied on a history obtained only from the mother that was supplemented by a standardized behavioral questionnaire from both the mother and teacher which indicated clinical levels of impulsivity, inattention, and oppositional behavior in both the home and school settings. The teacher wrote that Sara's performance could be very inconsistent, ranging from quite competent to out of control. The psychologist was aware of Sara's living in two separate households and acknowledged the possibility of the parents' very different parenting styles. The psychologist's diagnosis was ADHD (combined type) and oppositional defiant disorder. He recommended a behavioral program for home and school, counseling for Sara and her parents (not clear whether that included the biological father), and stimulant medication. After reading the report, Dr. Francis made two more calls to Mrs. Henry and left messages that she would like to meet with the mother. The calls were not returned.

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Index terms: ADHD, divorce, parenting conflict, family therapy.

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### Dr. Martin T. Stein

Two high-prevalence conditions that may have significant effects on the development of children are divorce and attention-deficit hyperactivity disorder (ADHD). The United States has the highest divorce rate of any developed country. Currently, approximately half of all marriages end in divorce, which translates to approximately one million children annually who experience their parents' divorce. The combination of single-parent births and divorce means that approximately 60% of all children at some time live in single-parent families. Other children are raised in a joint-custody arrangement that requires continuous cooperation and compromises by the divorced parents. One third of divorced parents report continued conflict with child-custody issues, and approximately 10% of divorces involve custody litigation. ADHD, in comparison, is the most common neurobehavioral condition among school-aged children. Recent community-based studies suggest a prevalence of 4% to 9%. This challenging case

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reflects the double jeopardy experienced by a child with both ADHD and divorced parents.

With joint custody following an amicable divorce and agreement about the most important child-rearing issues, adverse effects from these two conditions may not be additive. In a contentious divorce, however, the parents' anger and inability to grieve the loss of the marriage may heighten any differences they may have about a diagnosis or treatment in their child. The case of Sara illustrates this situation, which is seen frequently in a pediatric practice.

Two clinicians, a behavioral-developmental pediatrician and a family psychiatrist, have been invited to comment on this case. Their approach to Sara and her parents diverge and converge in different areas of concern. **Dr. Lawrence Diller** is a behavioral pediatrician who has written and lectured on ADHD, advocating a broader view of a child's behaviors that account for family, social, and educational environmental variables. **Dr. Roy Resnikoff** is a psychiatrist in practice who focuses his clinical work and teaching on the patient in the context of the family. He has taught courses and written extensively on family therapy. His contribution to the discussion provides a systematic framework toward understanding Sara's family and initiating interventions.

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#### **Dr. Lawrence Diller**

Experienced practitioners in pediatric care know that you do not treat just the child; the family is the patient.<sup>1</sup> No situation exemplifies this useful axiom more than the evaluation and treatment of children in high-conflict divorced families. The family maelstrom results in inconsistent affection and discipline of the children. Stress, tension, and sadness directly affect the children. These conditions in combination with children's temperamental vulnerabilities can lead to symptoms within the full spectrum of childhood "internalizing" (anxiety, depression, phobia) and "externalizing" (ADHD, oppositional behavior) disorders. The broad, sometimes ambiguous criteria for ADHD, along with the absence of definitive diagnostic markers, provide the "perfect" setting for a persistent difference of opinions.<sup>2</sup> Given the relative ubiquity of both divorce and ADHD, the problems presented in this case should be familiar to both primary care pediatricians and behavioral-developmental subspecialists.

According to the DSM-IV, the ADHD diagnosis technically indicates only a set of behavioral symptoms of inattention, distractibility, and/or hyperactivity. However, ADHD has come to mean "having" a neurobiological disorder that is believed to be inherently and genetically based. As a result of this biological focus and from empirical studies, stimulants (methylphenidate and amphetamine) are considered a primary treatment for the disorder. This case demonstrates that the clinician must look be-

yond a DSM-IV individually oriented, categorical, and biological ADHD diagnosis if he or she is to be helpful.

The environment of a continuing high-conflict divorced family—tension, arguments, screaming, physical threats, actual violence, monetary pressures, court dates—can by itself lead to the symptoms of ADHD in the children of these families. Technically, diagnoses such as acute stress reaction or adjustment disorder may more appropriately suggest the situational nature of the symptoms. On the other hand, such environments can exacerbate a temperamentally vulnerable child to appear as a case of flagrant ADHD. Family chaos is associated with a higher incidence of ADHD.<sup>3</sup> The nonspecificity of the response to stimulants is not useful in distinguishing between "true" ADHD and other diagnoses.

The variability of ADHD symptoms within different settings can create a Rashomon-like situation (Akira Kurosawa's 1951 film in which the story of a thief's attack of a nobleman is told by four witnesses, including a ghost; each narrator has a very different view of what actually happened), in which different caregivers in the family and extended system may have a different story to tell about the child. Indeed, they may all have a valid different experience. Typically, mothers will have more problems or at least be the most concerned about ADHD children. Mothers compared with fathers are generally more physically present and have more child/home responsibilities, even in biologically intact families. Mothers, stereotypically by virtue of gender, socialization, or culture, are more likely to be nurturing, have higher standards, and use more cognitive, conflict-avoiding parenting approaches than fathers. Fathers are more likely to use fewer words, act more immediately, and apply firmer discipline in their parenting. Authoritative parenting works best with the ADHD child, and there is some evidence that authoritarian-type fathers are even more successful with ADHD boys (and apparently not as successful with boys who have "normal" temperaments) (JF Mattanah, SP Hinshaw, unpublished).

It is not surprising that the most common conflict-view over ADHD in high-conflict divorced families presents like this case. Mrs. Henry thinks that there is a problem with Sara and seeks an ADHD evaluation. The mother receives feedback that there is a problem. Mr. Davis, on the other hand, perceives no problem with Sara. He is not involved in the evaluation and then is shocked and dismayed when a recommendation for stimulants is suggested. He believes the medication is unnecessary, inappropriate, and potentially dangerous for his daughter. Frequently hidden or long-standing conflicts about parenting, the marital relationship, and other issues add to the overt disagreement over the ADHD diagnosis and treatment.

Practice guidelines for ADHD stress the need for multiple informants and the value of standardized questionnaires as assessment tools.<sup>4</sup> The university psychologist, although information was obtained from the mother and teacher, failed to include the father's perspective in the evaluation. Too many

evaluations rely only on mothers' history of home and school behavior. If there is divorce or any hint of difference between parents, even in intact families, the clinical evaluation is strengthened when the evaluator makes strenuous efforts to contact and include each parent. Obviously, one gets a more complete picture of child and family functioning. It is important to note that interventions are more likely to be supported and followed when both parents are involved and united.

A "successful" medication experience goes beyond the simple pharmacological effects of the drug. Perceptions and attitudes about the medication affect the experience. Children's ambivalence about taking medications increases when close relatives criticize or object to the practice. Taking or not taking the medication becomes an act of disloyalty similar to a host of choices children in high-conflict divorced families must navigate.

Dr. Francis has several options. Some pediatricians might immediately refer this case because of their inexperience, lack of time, or fear of legal retribution. On the other hand, a pediatrician with a previous relationship with both parents may be the ideal facilitator between the parents. Dr. Francis could write a letter to both parents indicating the inadequacy of the first evaluation. She should stress the need for both parents' agreement over treatment to enhance the chances for a successful outcome. She could tell them how she understands that in the short term they risk feeling mistrust, anger, and sadness in working together. They will have to compromise to help their child, but she would support both of them in that effort. No further developmental testing of the child would be necessary; separate parent, child, and conjoint family interviews would be valuable. The teacher should be contacted again in light of the parents' differing perceptions.

If Mrs. Henry still refuses to participate, Dr. Francis is in a difficult position. An evaluation of Sara with only the father's input could duplicate or compound the initial error. Dr. Francis might suggest that the parents find another evaluator with whom both could agree. Alternatively, she could proceed with the evaluation without the mother's participation, or she might side with the psychologist's report while reassuring Mr. Davis and supporting him in accepting the use of medication. If Dr. Francis disagrees with the psychologist's findings, then a case of "dueling experts" arises, which mirrors the parents' conflicts. Ultimately, a recommendation for postdivorce counseling or mediation, preferably by someone familiar with children's behavioral and developmental problems, may be necessary. Indeed, decreasing tensions and differences between the parents might even lead to sufficient improvements in Sara's behavior so as to obviate the need for medication.

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### Dr. Roy Resnikoff

This case can be understood in terms of a dimensional approach to treatment. As a family psychiatrist, I have felt the need for the integration of methodologies, which has led me to view families along specific dimensions.<sup>1,2</sup> The dimensional model allows a clinician to view a range of therapeutic possibilities as a plan is formulated to begin the therapeutic process of dealing with the complexity of issues facing families. The four main dimensions include the following:

1. **Initial problem-solving versus background issues.** This dimension includes working from surface symptoms (Stage 1 of therapy) to communication and organizational issues (Stage 2) to personality style and opposing personality characteristics (Stage 3) and finally to life transitions and existential issues (Stage 4).
2. **Instrumental (change-oriented medical model) versus expressive-relational.** This dimension includes approaches within the family with a continuum from promoting practical problem-solving methods to promoting healing through conversation expression and awareness within the family.
3. **Biological factors versus environmental factors.** This dimension has neurobehavioral disorders on a continuum with environmental family dynamics.
4. **The clinician's promotion of the family's self-support versus providing active therapeutic interventions.** This dimension reflects a continuum from mediating family conflicts on the one hand versus attempting to create external therapeutic pressure toward "healthy" change or flexibility on the other. In this dimension, the clinician's biases regarding (1) favoring a particular stage of treatment, (2) having an instrumental versus expressive-relational style, and (3) biological versus environmental diagnosis either resonate with the family or do not.

The Davis family can be viewed along these dimensions both for assessment and intervention strategies.

*Dimension 1: Presenting Problem Versus Background Issues, Including Stages of Treatment.*<sup>3</sup> The surface presenting problem (Stage 1 of therapy) in the family is Sara's impulsive and disruptive behavior. Regarding the sequence of responses, the mother is very reactive and seeks outside help. The father uses everyday discipline to effectively control Sara and is critical of the mother for "overreacting." The



communication and organization difficulty within this family (Stage 2) is that there are two “bosses,” both having impact and who do not communicate. Stylistically (Stage 3), the mother and daughter are both action people who involve outsiders. The father, although also action-oriented, seems “lower key” and does not attract attention. Developmentally (Stage 4), the system is complicated by the divorce and step-parenting transition. In addition, Sara’s age (7 yr) developmentally involves the continuous process of separation utilizing peers and teachers that takes on a new significance while Sara is still relying on her parents for many decisions (such as health care). In Stage 4, suspiciousness and a lack of good will between Sara’s parents, including lawyers and defensiveness, dominate the divorce situation. The power struggle dominates over the best interests of Sara.

**Dimension 2: Instrumental Versus Expressive-Relational.** Both parents are using instrumental methods to help Sara. The father uses structure and discipline, and the mother seeks medication and outside expertise. No one is talking with Sara to find out how she is experiencing her impulses when they occur or how other children react to her. No one is asking Sara how she understands, accepts, or rejects her temperament or how she is experiencing the parental divorce and power struggle.

**Dimension 3: Biology versus Environment.** The family illustrates a mixed biological/environmental situation. Although it is likely that Sara is hyperactive and impulsive by nature, the parents’ dispute about her care and guidance is sure to create a family dynamic that causes additional anxiety and tension. Sara is “caught in the middle” of a parenting dispute and divorce communication problem.

**Dimension 4: Life Transitions and Existential Issues.** The transitional issues for the family system is the divorce, remarriage, and Sara’s developmental issues. No mention in the history is made of therapeutic, community, or spiritual support for this transition, and our culture, in general, gives very little support for divorce transitions.

The therapeutic intervention I have in mind would help enhance the therapeutic alliance by clarifying their situation in a positive way. Then, small corrective suggestions would be included to increase the possibility of the family’s participation in ongoing clinical help. Here is a possible letter to the family:

*Dear Steve and Carol,*

*In reviewing your care for Sara and her active temperament, I think you both understand her needs, but differ in your approaches. Steve, you have used a behavioral program with a great deal of effectiveness; and Carol, you have investigated the use of medication, which also would likely be helpful.*

*Unfortunately, however, I believe that even though you both have Sara’s best interests fully in mind, there may be unnecessary conflict in your two views of managing her. As a solution, I suggest a “research experiment” at home and school where behavioral methods are specified and used for 1 week (Steve’s plan), followed by a 1-week trial of medication (Carol’s plan). After the results are compared, a decision can be made to include medication on an occasional, regular, or not-at-all basis when she attends school. At home, regardless of the results, one option is to agree that Carol would use medication for Sara and that Steve would not.*

*Whatever your decision, it would be useful to discuss with Sara the*

*details of what you decide. It is essential that she be part of decisions regarding her treatment. I am very interested in being a support to your family while you work through this problem. It is likely that because of your power struggles, you may not be interested in outside help at this point, but when you are ready, I am available to have either a family meeting or a meeting between the two parents to discuss Sara’s needs.*

*Yours sincerely,*

Psychopharmacology, in this case, is considered for a medical diagnosis (ADHD). An additional way to conceptualize the use of methylphenidate would be to think of the medication as helping Sara communicate with others and to help her use words and conversation, in addition to action.<sup>4</sup> If the family were ever to consider family therapy, the expressive-relational style of the whole family would benefit from needed enhancement and expansion to balance the current predominant, practical, behavioral action, instrumental family style.

The therapeutic letter would hopefully help the family become aware of their power struggle even if the proposed experiment is not conducted. Also, each parent is redefined as caring and effective, further de-escalating the struggle and its anxiety-producing effects on Sara. Of course, the hope is that the family would consider the experiment and perhaps family divorce therapy. In the letter, I omitted getting into the legalistic power struggles and have, instead, only offered positive steps toward change.

Pediatricians working with Sara’s family (using the fourth dimension above) would need to be self-aware regarding their own preferences for biological versus environmental etiologies and their own preferences for instrumental approaches (biological or behavioral) versus expressive-relational approaches. The ability for the clinician to have flexibility along these dimensions would be optimal.

In summary, by using a dimensional approach, the clinician can appreciate both the surface biological issues and the political struggles within the family, and he or she can anticipate steps toward creating a therapeutic alliance. By joining and redefining the two instrumental parental approaches, the clinician can begin mediating between the behavioral and medication approaches and open the door to more open discussion and communication regarding divorce issues, Sara’s temperament struggles, and Sara’s developmental needs.

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## Web Site Discussion

This Challenging Case was posted on the Developmental and Behavioral Pediatrics web site\* ([dbp@pedscme.med.usf.edu](mailto:dbp@pedscme.med.usf.edu)) and the *Journal's* web site (<http://www.wwilkins.com/DBP/>). The following comments added other insights to the discussion:

**Allen Moulton, MS, RN, MSN**, from Stowe, Vermont, wrote: "As I see it, one approach to this difficulty would be a friendly but firm note to the psychologist suggesting that he consider amending his report to include input from father. In my state, it would possibly be considered unethical to present such an evaluation without input from both parents. . . . it seems the psychologist has (perhaps unwittingly) become an ally for mother against father and should be given an opportunity to modify her conclusions. If she refuses, it may be necessary to become a bit more assertive. I cannot see a good resolution as long as this one-sided and incomplete evaluation is left intact. The difficult part is for the father and his advocate to avoid increasing tension and mistrust and to maintain the focus on meeting the child's needs in a way that is acceptable to both parents. How that may best be managed would depend on how strong the mistrust is and how much each parent is capable of considering the best interests of their child."

**Henry L. Shapiro, M.D.**, from St. Petersburg, Florida, wrote: "This Challenging Case is unusual only because the father brought his concerns back to the pediatrician. In this case, the pediatrician has another chance to make sense out of the situation. I wonder if the pediatrician was involved to begin with, or whether the mother went to the psychologist on her own? If the pediatrician had been consulted to begin with, perhaps the issue of the different perspectives could have been brought to light sooner.

"From a practical point of view, it would have been better if the psychologist had addressed the issue more directly and sought input from both parents, even if it was in the form of having them both complete an Achenbach Child Behavior Checklist. While performance inconsistency is a major component of the ADHD diagnosis, the limited information available suggests less of a problem with performance and more of a mood/adjustment problem. We don't know how long the symptoms have been present, and we don't know why psychostimulants are being recommended as initial therapy. In short, there is a big focus on the child's behavior and not much emphasis on underlying issues. I think it is important that the pediatrician not get in the middle of this battle, but remind the parents of the child's

needs so that they don't get lost in the shuffle. Bravo for the pediatrician willing to listen to both parents. The father also deserves credit for talking with the pediatrician privately."

## Dr. Martin T. Stein

My interest in the case of Sara and her parents derives from a sense that pediatricians do not participate in a predictable way with families who are either in the process of a divorce or in the case of a conflictual divorce that continues to affect the development of a child. In a survey of parents, only 7% identified pediatricians as a resource during divorce.<sup>1</sup> This is in contrast to the long-term relationship that a pediatrician develops with a family during numerous health supervision and acute illness visits.

The therapeutic alliance based on trust and availability is the foundation for a pediatrician's role in anticipatory guidance and helping families at times of change and stress.<sup>2</sup> Sara's pediatrician, Dr. Francis, serves as a model for the expression of concern and willingness to embrace the uncertain course of events that face a professional who works with parents and children during a conflictual divorce. Although not successful at first, she reached out to Sara's mother in an attempt to assist the parents in finding a common ground.

Pediatricians should recognize that divorce is a long-term process initiated by increasing marital discord followed by separation and a lengthy, sometimes hostile, court process. Even after a final settlement, there is both an acute and chronic period of adjustment for the parents and children.<sup>3,4</sup> A divorce can be conceptualized as a profound loss similar to death in which there is a period of initial denial or disbelief, a gradual acceptance, a readjustment, and redefinition of the family unit.<sup>5</sup> In the most conflictual divorce, court battles over money and custody can last throughout childhood and adolescence.

Considering the frequency of divorce and ADHD, variations on this case are probably familiar to most primary care pediatricians. My own clinical experience has been to go slowly, exploit the therapeutic relationship, and take the long view. Dr. Diller correctly observed that the evaluating clinician made the diagnosis of ADHD with only half of the data; the father's absence during the diagnostic process may have prevented a distinction between ADHD and either an acute stress reaction or an adjustment disorder.

Dr. Resnikoff's letter to Sara's parents is an extraordinarily sensitive and therapeutic initiative in this direction. An invitation for an office visit with each parent individually has been a useful strategy in my practice. It provides the parents an opportunity to discuss their own ideas about ADHD and medication and, simultaneously, to explore their feelings about the condition and treatment in the context of the differences between the parents. One or two meetings with each parent often afford opportunities for education and negotiation. On several occasions,

\*A bimonthly discussion of an upcoming challenging case takes place at the Developmental and Behavioral Pediatrics web site. This web site is sponsored by the Maternal and Child Health Bureau and the American Academy of Pediatrics section on Developmental and Behavioral Pediatrics. Henry L. Shapiro, M.D., is the editor of the web site. Martin Stein, M.D., the Challenging Case editor, incorporates comments from the Web discussion into the published Challenging Case. To become part of the discussion at the Developmental and Behavioral Pediatrics home page, go to <http://www.dbped.org>.

the parent who was originally resistant to either the diagnosis or pharmacotherapy agreed to a monitored trial on and off stimulant medication. Weekends were included to allow each parent to observe their child's behavior on and off medication. If ADHD core behaviors were improved, the next step was to bring the parents together at an office visit to negotiate a mutually acceptable medication schedule. A pediatrician's role is to assist the parents in finding areas of care they can agree on with a recognition that both parents and the pediatrician are working toward the child's best interest.

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