CONCEPTUALIZING ADHD AS A CONTEXTUAL RESPONSE TO PARENTAL ATTACHMENT

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This article suggests that attention deficit hyperactivity disorder is frequently misdiagnosed, even overdiagnosed, and provides an alternative way of viewing such problem behaviors in children. It presents a framework, based on systems and attachment theory, that views children's behaviors within the context of the parent–child attachment patterns, and it suggests interventions that shift the focus from the child to the parent–child interaction.

Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) are increasing at an alarming rate, exceeding 2 million reported cases nationwide in 1995. Children with ADHD diagnoses account for approximately half of the child referrals in child mental health agencies (Daw, 1996). In spite of the impact these children's behaviors have on family interactions, family therapists have given minimal attention to the assessment and treatment of ADHD. The majority of the research done on ADHD children has been reported in educational and child psychology journals, and some of the more recent research even challenges the accuracy of many ADHD diagnoses (Armstrong, 1996; Smelter, Rasch, Fleming, Nazos, & Baranowski, 1996).

It has been suggested "that the diagnosis meets the needs of the parents more than it does those of the child" (Smelter et al., 1996, p. 430) and may even relieve parents and teachers from further responsibility of dealing with the child's frustrating behaviors. It is time for family therapists to respond to this problematic issue from a contextual framework and look at the family dynamics and interactions of ADHD children, rather than

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isolated behaviors of the child (Bretherton, 1992; Moretti, Holland, & Peterson, 1994; Webster-Stratton, 1990). The purpose of this article is to provide an alternative way of viewing problem behaviors in children that is embedded in attachment theory. Although these behaviors might resemble ADHD or other disruptive and aggressive behaviors in children, they will be explained within the context of parental attachment patterns. It should be emphasized that it is not the intent of this article to refute the existence of ADHD diagnoses: No doubt the disorder does actually exist. Instead this article explains how parent–child attachment patterns may actually provide a context for explaining problem behaviors in children that may otherwise be interpreted as ADHD behaviors. It is hoped that this way of viewing ADHD may result in interventions that address ADHD as symptomatic behaviors, thereby enhancing the possibilities for change. Additionally, it is a way "to explore the full future potential of attachment theory" by "refining, extending, and challenging it" (Bretherton, 1992, p. 771).

OVERVIEW OF ATTACHMENT THEORY

Attachment theory evolves from the basic premise that attachment behaviors are part of a drive–behavioral system organized around specific attachment figures (Bowlby, 1969, 1988). Infants attempt to establish a secure base with a primary caregiver, usually the mother, from whom they later develop appropriate exploratory behaviors. This parent–infant interaction is referred to as "exploration from a secure base" (Ainsworth, 1967). When children feel threatened by environmental factors that endanger their security, they attempt to re-establish proximity with the attachment figure to regain a sense of security. If the attachment figure responds positively by providing nurturance and reassurance, the child develops a secure attachment with that figure and is thereby encouraged to pursue future exploration. If the attachment figure responds negatively, by avoiding the child's needs or inconsistently responding to them, the child develops an insecure attachment. Hence, future exploratory attempts are discouraged or become extremely stressful for the infant to carry out. The response by the attachment figure as he or she she interacts with the infant, either positively or negatively, becomes encoded in the child's mind and is referred to as the *internal working model* (Bowlby, 1988; Crittenden, 1990).

There were originally only two categories of insecure patterns, referred to as *avoidant* and *ambivalent* by Ainsworth, Blehar, Waters, and Wall (cited in Lyons-Ruth, 1996). However, an additional category was later described and labeled *disorganized* by Main and Solomon (cited in Lyons-Ruth, 1996). It is the avoidant infant behaviors that occur in a disorganized manner that are associated with later aggressive behaviors (Lyons-Ruth, 1996).

Byng-Hall (1985, 1990) and Byng-Hall and Stevenson-Hinde (1991) expanded on Bowlby's concept of the intergenerational transmission of attachment patterns, first addressed by Main and Kaplan (1985), by applying the term *family scripts*. Byng-Hall viewed these scripts as shared working

models of attachment behavior that develop by participating in, or observing, attachment behaviors in one's own family (Byng-Hall, 1990, 1995). He described four ways that insecurities in one relationship can spoil the security of another relationship: by (1) turning to an inappropriate attachment figure (e.g., a divorced parent turning to a child for comfort), (2) competition for an attachment figure (e.g., a jealous child who clings to a parent because he or she cannot tolerate the parent's relationship with other family members), (3) a defensive response to attachment cues (e.g., a parent who failed to acquire a model from his or her own parents to tolerate normal attachments), and (4) anticipation that the past may be repeated (e.g., a child who refused attachment to avoid the painful consequences of anticipating the repetition of a previous traumatic loss). Others (Crittenden, 1992; DeKlyen, 1996; Lieberman & Pawl, 1990) also have explored the lifetime development and transmission of attachment patterns. The suggestion that attachment patterns may be a learned response passed down from one's family of origin explains the recursive nature of parent-child interactions. The mother who never experienced a secure response from her parent will be less likely to respond securely to her own child during times of stress, thus resulting in an insecure base upon which that child will build future relationships.

CONTEXT OF CHILDREN'S BEHAVIORS

Crittenden (1992) suggested that in treating children with behavior problems it is important to consider their behaviors in the context of their function, rather than to simply look at isolated overt behaviors. Bates and Bayles (1988) considered three interacting influences in assessing children's behavior problems, all within the context of the parent–child attachment relationship: (1) the ethological factors, which are at the fundamental biological level; (2) the cognitive–affective factors, which assess the child's attitudes toward the attachment figure (i.e., mother); and (3) the social system, which looks at the relationships the child develops within his or her environment. They also considered the role that the child's temperament plays as an interactive factor in the parent–child attachment process.

It has also been suggested that family variables, such as adolescent and single parenthood, marital discord, financial stress, and parenting styles (Lyons-Ruth, 1996; Patterson, 1986; Webster-Stratton, 1990), as well as individual variables, such as maternal depression, anxiety, and alcohol and drug use (Cummings & Cicchetti, 1990; Lyons-Ruth, 1996; Webster-Stratton, 1990), tend to be associated with disruptive or aggressive behaviors in children. Lyons-Ruth (1996) found that infant disorganization patterns were associated with later development of highly aggressive behaviors in children and that disorganized behaviors in children increased with incidence of maternal alcohol consumption, maternal depression, adolescent parenthood, and parents' unresolved losses or traumas. DeKlyen (1996) examined the link between childhood disruptive behavior disorder, the quality of the mother–child interactions, and the mother's recollections of her attitudes toward her own parents. On the basis of the mothers'

responses to the Adult Attachment Interview (Main et al., 1985), which was developed to assess how adults perceive their childhood experiences to influence their own parenting, she found that insecure mothers were more likely to report disruptive experiences, such as divorce or separation, during the child's lifetime.

DeKlyen (1996) also proposed that the difficulty that insecure mothers have in relating intimately with others may also contribute to a reduction of opportunities for their children to learn good interpersonal skills. Infants with secure attachments to parental figures exhibit positive social behavior toward both parents and peers (Lyons-Ruth, 1996). Speltz (1990) explained conduct problems—which he defined as chronic noncompliance, aggressiveness, and frequent discontrol—as an outcome of the absence of immediate, consistent, and developmentally appropriate parental responses to children's behaviors. A study by Patterson (1986) linked antisocial behaviors in boys with academic failure, rejection by peers, low self-esteem, and parents who lack management skills. Mother–child conflict has been found to be greater in children with diagnosed behavior problems, and negative control techniques, such as criticism, have been found to correlate with defiance in toddlers and school-aged children (Campbell, Pierce, March, & Ewing, 1991).

Although Cummings and Cicchetti (1990) and Cummings and Davies (1994) did not find a direct link between parental depression and insecure attachments, they identified it as a significant risk factor. The implication of these studies is that when parental response to children is impaired by interference from external variables, children react in disorganized, detached, and disruptive ways. The circular nature of these interactions then reinforces a pattern of coercive exchange between parent and child (Crittenden, 1992; Lyons-Ruth, 1996; Moretti, Holland, & Peterson, 1994; Patterson, 1986; Webster-Stratton, 1990), hence solidifying a detached and insecure parent–child relationship.

ADHD BEHAVIORS AND COERCIVE INTERACTIONS

ADHD is classified in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed. [*DSM–IV*]; American Psychiatric Association, 1994) as one of the disruptive behavior disorders, along with Oppositional Defiant Disorder and Conduct Disorder. Children with ADHD are described as having developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity. At home, they fail to follow through with others' requests, shift from one uncompleted task to another, and often interrupt or intrude on other family members. Familial environments that are disorganized, chaotic, or neglectful are viewed as predisposing factors in ADHD diagnoses (American Psychiatric Association, 1994).

Smith (1994) described similar types of behaviors in children she was treating, who ranged in age from infancy to 18 years. These children exhibited classical symptoms of ADHD, and they also showed extreme violent outbursts. Smith's study was intended to show how treating the serotonin neurotransmitter system of the children eventually brought the violent

behaviors under control after all other types of therapeutic interventions and behavior management programs had failed. Additionally, however, it exemplified how out-of-control behaviors in children can enforce unrealistic demands on parents that eventually result in parents developing low self-esteem and perceiving themselves as failures. This, in turn, makes it difficult for parents to establish appropriate hierarchies in the family, reinforcing opportunities for children to dominate the family. Twenty-five percent of the infants in this study screamed and cried violently unless their mothers carried them everywhere throughout the day. Consequently, the mothers became hostile and rejecting toward the children and reacted in a disattached way toward them. When the aggressive behaviors were controlled, the mothers were able to bond and attach to their children.

Campbell et al. (1991) noted how the interaction between noncompliance and overactivity in children predicted high levels of negative control by parents and that noncompliance and negative maternal control cooccur in parent–child relationships. Greenberg and Speltz (1988) noted that insecure children coerce parents into caring for them by acting disruptively and demanding. Such behaviors, when coupled with overcontrolling parents, result in competitive attempts on both sides to prevail. Patterson (1986) found that such trivial behaviors as whining, teasing, and yelling can mark the beginning of aggressive family interactions. Parents who start out with poor management skills and encounter such problem behaviors in children react by threatening, nagging, and scolding the child. They seldom follow through with their threats, however, and become frustrated and eventually explosive. The children react by counterattacking the parent, which creates an attack–counterattack pattern. The children and parents both become more skilled at their coercive attacks toward the other, until the child becomes completely out of control. By this point, both have also begun to emotionally detach from the other. It is easy to see how a parent may develop a similar pattern of attack–counterattack by becoming emotionally and physically unattached at the onset of the problem behaviors, reinforcing the child's whining and nagging behaviors.

Crittenden (1992) described how insecurely attached children develop strategies to allow themselves to explore the environment in spite of their caregivers' unavailability. They alert their caregivers to fearful situations by using anger, which gives the child a false sense of power. Such demanding and helpless behaviors from the child, who is actually powerless, encourage negative involvement from the attachment figure, which only increases the child's feelings of anxiety and vulnerability.

Moretti et al. (1994) described how caregivers of coercive children are frequently unresponsive to their needs, and when they do respond it is with anger and negative affect. These children alternate between a facade of vulnerability, which lures the caregiver into caring for them, and aggressively forcing their parents to meet their needs. In interactions such as these, attachment figures respond to only the most intensive and extreme behaviors. Therefore, it is incumbent on the child to do whatever it takes

to successfully engage the caregiver (Lyons-Ruth, 1996; Webster-Stratton, 1990). In script terminology, the child may desperately attempt to capture the parent, leaving one parent feeling overwhelmed and smothered while the other one feels neglected and left out. The result is that both parents lose their hierarchical positions and control of the child (Byng-Hall, 1995). This, as in the scenario above, sets into motion a reciprocal exchange of coercive and demanding behaviors between the parent and child.

The kinds of coercive patterns described here that exist in the context of parental mismanagement are similar to the kinds of behaviors described by parents of ADHD children. To obtain an ADHD diagnosis, children are required to meet at least six behavioral criteria in at least two settings. These criteria include individual behaviors, such as fidgeting, inattentiveness, and excessive movement and talk and also address interpersonal behaviors, such as difficulty playing or engaging with peers, interrupting and intruding on others, and not listening when spoken directly to (American Psychiatric Association, 1994). The similarity between children being brought to therapy for ADHD behaviors and the children reacting to attachment issues is startling. It is at this point that the question is presented: "Is this child truly an ADHD child, or is he or she simply engaging the necessary defenses to survive in such an insecure environment?" The only way to know is to consider the context in which these behaviors thrive.

Although insecurely attached children may not meet all of the ADHD criteria, many of them are frequently observed. Even more so, children are often brought to clinicians with dubious and incomplete ADHD diagnoses. ADHD diagnoses are usually determined from behavior rating scales, which depend on subjective judgments by teachers, parents, or both, who may have a vested interest in the outcome (Armstrong, 1996). Another concern is that it is difficult to clearly differentiate between what is normal high activity in children and when it becomes ADHD. It has been my own clinical experience that children are often referred with ADHD after a single assessment that frequently has been completed by only one person. Even the diagnoses that are clinically valid send a message to the parent and to the child that the problem lies within the child, when in reality it is a family issue. Clinical observations also indicate that parents frequently enter therapy in a state of desperation, after having tried harder and harder to correct the child's problem, usually by doing more of the same or increasing the intensity of correctiveness. The obvious result is a neutral effect on the child, at best, and more likely results in an angry, aggressive, resistant child.

IMPLICATIONS AND TREATMENT

The repercussions of viewing ADHD as an individual problem to be treated solely with medication, behavioral management strategies, or both, has serious implications. Children who are already frustrated and anxious over the lack of a parental bond will feel more victimized if they are focused on as the problem. The one positive side of such a unilateral

approach as medication is that it probably will improve some of the problem behaviors and induce a calming, positive reaction in the child, thus possibly reducing the coercive behavior patterns. Hence, the mother and child both could more easily engage in positive, supportive behaviors rather than the attack–counterattack pattern that is so familiar to them.

A second concern is that behavioral strategies, such as reward systems and token economies, may provide a Band-Aid effect on the parent–child relationship. It has been noted that children can selectively display ADHD behaviors in one situation while appearing normal in another (Fachin, 1996). This alludes to the capriciousness of ADHD behaviors in children and how they can so effectively maintain a distant and detached parent–child relationship.

Because ADHD behaviors are usually first identified in school settings, it is important for school counselors to have opportunities to consult with family therapists regarding children's problem behaviors. Therapists trained in systems theory are more likely to consider the context of children's behaviors and less likely to label disruptive, aggressive, avoidant behaviors in children as ADHD or conduct disorders. By approaching these problems systemically, therapists can work toward addressing the attachment issues between the parent and child and alleviating the function of the disruptive behaviors. It also is important to avoid a linear perspective of these families, which tends to blame the parent for the child's behavior.

Moretti et al. (1994) described a 30-day residential program for working with conduct disorder children that is based on attachment theory. The program involves interventions that address attachment issues by reframing the behavioral problems into attachment terms. The result is a reciprocal modification of dynamics between the parents and the children. As the parents learn to modify their interpretations of the children's behaviors, the children feel less criticized and become more compliant, thus allowing the parents to become more responsive to their needs. The circularity of this approach provides an environment in which mutual connectedness can develop.

Bowlby (1988) also identified five therapeutic tasks to help clients restructure their representational models of attachment. These include providing a secure base for clients to explore painful aspects of their pasts and to help them become aware of how their current perceptions are products of their past memories and beliefs. It is hoped that an approach such as this will allow the parent(s) in therapy to reassess their role in their child's behavior patterns and to begin to mend some of these wounds.

Byng-Hall (1990) emphasized the importance of joining with all family members to model a nonexcluding style of acceptance with everyone. He considered this process a vital component in therapy that establishes a temporary secure base from which the family members can review their family scripts of attachment patterns. He also suggested that reframing the behaviors as serving a function in the system is the most effective way to begin forgiving.

RECOMMENDATIONS FOR FUTURE RESEARCH

Although attachment theory has been linked to conduct disorders and other behavioral problems, it has not been linked to ADHD behaviors. Because ADHD diagnosis appears to be gaining popularity as a "catch-all" for many behavioral problems, it is crucial that professionals are careful in assessing the validity of ADHD diagnoses and that they have an alternative way of viewing what may appear, or is reported, to be ADHD.

It is obvious that empirical research is needed to validate the assumptions of the function of ADHD behaviors within an attachment context. Additional variables that affect family functioning, such as income level, divorce, stress, mental and physical functioning of parents, and so on, need to be addressed in relation to ADHD behaviors. Intervention programs that conceptualize ADHD within a contextual framework need to be compared with more traditional programs to assess their effectiveness. With the distressing increase of ADHD diagnoses, it is evident that it is a serious concern among therapists as well as among teachers. I hope that we will be willing to view this problem through a new lens to provide hope for those who live with the frustrations of ADHD.

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