Hyperactivity: The Family Factor

Researchers are looking at the controversial diagnosis and treatment of childhood hyperactivity through a familial lens

By BRUCE BOWER

Methylphenidate hydrochloride, a stimulant drug better known as Ritalin, is back on the hot seat. Although physicians have used it since the 1950s to treat children and adults with attention-deficit hyperactivity disorder (ADD), often referred to simply as hyperactivity, there have been recurring concerns that the drug is prescribed too freely for all sorts of behavior problems.

Last November, for example, a Georgia mother filed suit against a public school district, charging that school-instigated methylphenidate treatment had made her son violent and suicidal. Her suit also contends the definition of attention-deficit hyperactivity disorder drawn up by the American Psychiatric Association is overly broad and invites misuse of the drug.

Psychiatrists generally agree that methylphenidate often has a role, along with psychological and behavior modification approaches, in the treatment of ADD. But uncertainties over who benefits most from which treatment will persist, says psychiatrist Peter S. Jensen of Eisenhower Army Medical Center in Fort Gordon, Ga., until investigators address a much-neglected influence on the child with ADD: his or her family.

Research at an ADD clinic for children of military personnel indicates that the disorder often reflects a youngster's depression or anxiety, Jensen reported at the American Psychiatric Association's recent annual meeting in Montreal. He and his colleagues also find ADD is associated with an increased number of stressful events affecting a child's family and the presence of psychiatric symptoms in parents.

"These children's attention problems are merely one of a number of significant problems affecting them and their parents," he says.

Jensen's preliminary findings point to several important family factors involved in attention-deficit hyperactivity, notes psychiatrist Mina K. Dulcan of Emory University in Atlanta, but they also emphasize the need for more rigorous comparisons of the home life of children with and without ADD.

Jensen and his co-workers compared 68 military offspring with ADD to 200 children without psychiatric diagnoses seen by military physicians. The average age of the youngsters was 9½ years. ADD children reported significantly more symptoms of depression and anxiety than the comparison group. Parent reports confirmed that more than half of the hyperactive subjects suffered from a mental disorder involving depression, anxiety or both.

In addition, says Jensen, parents of ADD children reported elevated levels of depression and anxiety as well as experiencing more stressful events, such as marital difficulties, divorce and hospitalization, in the previous year.

Drawing conclusions about the causes and effects of childhood ADD from results such as these is a tricky business, Jensen acknowledges. Children's symptoms may result from their parents' difficulties, or the parents' symptoms may be due to the stress and frustration of dealing with a hyperactive child. Another possibility is that a common genetic factor contributes to both adult and child psychiatric problems.

But the overriding theme of the findings, in Jensen's view, is that ADD is often only one of a number of psychiatric problems affecting many ADD children and their parents. This idea, contends Jensen, goes beyond the official psychiatric definition of ADD, which focuses on three areas of behavior: inattention (such as difficulty concentrating on or finishing school projects), impulsivity (such as interrupting others and blurting out answers to questions before they are completed) and hyperactivity (including difficulty staying seated and sitting still without fidgeting).

When anxiety, depression, stressful events and parental psychiatric problems are mixed in with attention-deficit hyperactivity, Jensen says, effective treatment must include the entire family. At the Eisenhower Army Medical Center ADD clinic, parents of hyperactive children participate in support groups under the direction of psychiatrist Robert E. Shervette.

"The parents tend to help one another more than the staff can," Shervette says. Group participants share their child-rearing experiences and develop more compassion for their children. As sessions progress, parents often begin to unravel the ways in which family members habitually interact and reinforce one another's behavior.

Another treatment strategy aims at increasing the blunted sense of control and introspection observed in many ADD children, Shervette says. The youngsters learn to regulate their heart rate through biofeedback training, a process that requires quiet concentration and provides clear confirmation of success or failure after each trial.

"We're not blaming parents for the child's problems," maintains Shervette. "These kids can put even the most patient clinician in a ballistic mood."

In many cases, he notes, something seems to have gone awry in the early emotional "attachment" that takes place between parents and child. The concept of attachment, originally developed by British psychiatrist John Bowlby, refers to an emotional bond formed between an infant and one or more adults, usually the parents. Under normal circumstances, the infant seeks out attachment figures in times of illness or distress, and becomes anxious if separated from them.

Shervette and his colleagues interviewed the parents of 50 ADD children about incidents likely to have disturbed or threatened early attachment. Two-thirds of the parents said the child had been the product of an unplanned pregnancy. About half of them reported threatening to give the child away at some time. Given these reports, says Shervette, it is perhaps not surprising that 90 percent of the ADD children were second- or third-born. And two-thirds of the children had been hospitalized during infancy, interrupting daily contact with parents.

Although the results are intriguing, they underline the need for more intensive family research. "Mental health practitioners need to ask whether there are events in the family that lead to or worsen a child's [hyperactive] symptoms," says Shervette.

Taking this investigative tack might also clarify the circumstances under which methylphenidate should be used, Jensen notes. "In our clinic, we find that about 30 percent of the children on medication [prescribed by pediatricians] should not be taking it," he says. "They either respond to placebos just as well or actually get worse on the active medication." □

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