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ADHD or Not ADHD: Custody and Visitation Considerations

By Benjamin D. Garber, Ph.D.

PROFESSIONALS INVOLVED WITH family law matters, particularly those who participate in contested custody issues, special education placement and even abuse and neglect concerns, have all come face to face with the ADHD monster.

Attention Deficit (Hyperactivity) Disorder (ADHD) is perhaps the most often diagnosed, most often medicated and least well understood mental health concern among school-aged children today. For this reason, family law professionals must have a working understanding of what ADHD is, what it is not, and how it bears on custody and visitation concerns.

What is ADHD? Once known as "Minimal Brain Dysfunction" and "Hyperkinetic Reaction of Childhood," this constellation of dysfunctional or disruptive behaviors is today recognized by the American Psychiatric Association as ADHD. The prototypical ADHD child is three times more likely to be male than female, has at least one parent (more likely father than mother) with similar dysfunctional patterns and can be identified in hindsight as having had behavioral difficulties as early as three to five years old.

ADHD children are no less intelligent than their age-mates, but tend to be markedly more impulsive and inattentive than peers of the same age and gender. Even this is misleading, however, because ADHD kids *can* concentrate. It's not unusual for the parents of an ADHD child to argue, for example, that their son can sit for uninterrupted hours in front of his Nintendo. The critical difference only appears when the ADHD child needs to concentrate in an environment that presents many simultaneous sources of sensory input. Compared to his peers, the ADHD child has a much more difficult time filtering out unimportant (incidental) sensory inputs in order to remain focused on the critical sensory inputs.

The typical public school classroom may be the ADHD child's greatest challenge. Seated randomly among 20 or more peers, surrounded by colorful bulletin boards, mobiles hung from ceiling tiles, enticing activity centers, panoramic views of the outdoors and bombarded by the incident noises that leak in from adjoining classrooms, corridors and P.A. systems, it's a wonder that any child can focus on the math lesson spelled out in white chalk 20 feet away. Relatively unable to ignore all of these many simultaneous and competing stimuli, the ADHD child takes in a bit of everything, but rarely enough of any one thing. Grades suffer. Teachers criticize. Peers shun and make fun. Self-esteem plummets.

In recognition of this destructive spiral of events, the American Academy of Pediatrics' (AAP) new diagnostic guidelines for ADHD emphasize that, "evaluation of the child with ADHD should include assessment for coexisting conditions" including depression, anxiety and learning disabilities. The fact is that a number of common childhood mental health conditions may exhibit symptoms that resemble ADHD and are therefore often mistaken for ADHD, a dilemma which is at least as common as it is destructive.

The chicken or the egg?

For family law practitioners representing clients in a difficult divorce, an ADHD diagnosis of a child or children should be closely examined. What may appear to be a contributing factor to the divorce may actually represent something else: behaviors that are symptoms of the trauma of family conflicts. And whether or not the child is truly afflicted with ADHD or exhibiting behaviors associated with a difficult phase of his or her life could have an impact on the best course for litigation.

Which came first? Is the inattentive child depressed and anxious because his neurochemistry creates what one researcher has called a "failure of behavioral inhibition," leading the child to expect constant criticism, failure and rejection experiences? Or is the depressed and anxious child inattentive because intrusive worries about traumatic events, loss and fears interfere with an otherwise normal capacity for concentration?

Clues to the ADHD dilemma lie in understanding a given child's family tree, in the longevity of the

concerns about the child and in as-yet impractical, but promising, neural imaging and neurochemistry studies. Until science creates a tool as definitive of ADHD as the x-ray is of bone fractures, the cause of a given child's inattention will remain a matter of heated debate. Heated debate about children is, after all, what family law is all about.

Before they reach your office

The family law matters that walk in most attorneys' front doors-the domestic violence, restraining orders, child visitation and custody complaints-each have long and painful histories. The kids have lived these histories minute by minute, watching their families disintegrate. In fact, children are barometers of family tension, registering parental fears and rage and sadness better than the best meteorological instruments register the weather. Don't believe those highly educated, socially sophisticated parents who tell you they've kept the kids out of it. They may, indeed, have saved their children from the pain of outright alienation, abandonment and violence, but the kids still feel it. Sometimes silence is even louder than screaming.

These same family law matters are exactly the right circumstances in which to breed childhood depression, anxiety and anger, variously labeled Oppositional-Defiant Disorder, Intermittent Explosive Disorder and Conduct Disorder. These conditions, in turn, often cause a child to be disruptive, distracted and inattentive in the classroom, signs and symptoms most easily associated with ADHD.
Parents' denial of or simple wish to avoid facing a larger family or marital problem frequently compounds this misidentification. Many children are misdiagnosed with ADHD and inappropriately medicated because all involved have implicitly conspired to scapegoat that child rather than face the reality of the situation. Unfortunately for everyone, especially the stigmatized, medicated child, this strategy rarely succeeds in alleviating the family or marital issue at the root of the problem.

The impact on family law

There is a substantial difference between a child who genuinely has ADHD and one whose behavior and learning have been disrupted by long-standing family turmoil. After all is said and done, the child with genuine ADHD has a chronic disability that will require careful intervention, support and behavior management for years to come. On the other hand, a child misdiagnosed with ADHD may instead be reacting to difficult situations at home, circumstances that the divorce court is often in a position to modify.

In responding to family law matters involving children for whom ADHD has been diagnosed or suggested, professionals should look beyond the labeling and consider whether the environment of a deteriorating family relationship has contributed to the presence of symptoms that mimic ADHD.
First, the family should be prepared-as definitively as possible-to investigate whether ADHD actually exists. The diagnosis of ADHD requires comprehensive assessment of a child's functioning in different areas and contexts by a multi-disciplinary team of professionals. This must include, at a minimum, physical examination, vision and hearing evaluations, tests of intelligence and achievement (in an effort to rule out learning disabilities), review of family and developmental history, classroom and family observations and completion by teachers and parents of structured assessment tools (e.g., Connors' Rating Scale).

If ADHD diagnosis is confirmed

When these data converge to determine the presence of genuine ADHD, a child-specific constellation of interventions and supports must be established to optimize achievement and minimize the potential for secondary depression, anger and anxiety. These interventions often include individual cognitive-behavioral psychotherapy, behavior management planning with parents and teachers, medication consultation and consideration of a 504 or Individualized Educational Plan (IEP) in the schools.
The presence of genuine ADHD calls for a high degree of structure, predictability and consistency in all contexts of a child's life. Caregivers must be willing and able to learn about ADHD, to modify pre-existing behavior management strategies in consultation with professionals and in cooperation with co-parents and educators. The presence of ADHD makes the need for constructive communication between parents and caregivers all that much more important. Of particular concern is the ability of caregivers to agree on critical decisions for the ADHD child including academic identification for an IEP and medication.

A caregiver that disregards these supports may well be compromising the child's educational achievement and putting the child at risk for serious secondary social and emotional concerns. The consistency, structure and many decisions necessary in the course of raising a child with ADHD are crucial, requiring constant reconsideration and modification. Given the high degree of cooperation involved, it may be necessary for the courts to assign one party as the medical/mental health decision-maker for parents in shared custody arrangements that are unable to consistently communicate and cooperate.

If it* isn't *ADHD

The determination that a child's ADHD-like symptoms are secondary to a reactive emotional state calls for another approach. In this instance, the child's dysfunction and distress may reasonably be expected to diminish once the family turmoil subsides (although often lagging behind by weeks or months). The converse is true, as well: The more prolonged and heated the family strife, the worse the child's symptoms may become. This situation obviously calls for a prompt resolution of the family turmoil.

A circular and destructive situation arises when family law decision-making is weighed down by arguments about a child's needs when, in fact, the child's needs might best be served by a prompt resolution to the family law matter. The distinction between primary ADHD and its reactive, ADHD-like cousin is again relevant here. The genuine ADHD child's need for multiple, coordinated interventions and supports may reasonably delay court proceedings and benefit this child in the long run. By contrast, the child with reactive ADHD-like symptoms often gains little and risks losing a lot when family law decision-making is protracted.

Certainly, genuine ADHD and family-reactive ADHD-like distress can coexist and often do. In fact, the parenting demands and stresses posed by a hyperactive, inattentive and defiant child can be the straw that breaks the back of the marriage, creating family turmoil which adds a layer of depression, anxiety and/or anger to the child's pre-existing ADHD. In these cases it can be difficult or impossible to pull these two factors apart clinically, leaving conservative professionals to diagnose that which is behaviorally evident (Oppositional-Defiant Disorder, for example) while conceding that ADHD may underlie or co-exist with these concerns. In these situations, perhaps the only adequate diagnostic tool is cessation of the family conflict long enough to determine whether underlying inattention, distractibility and impulsivity persist.

No matter the genuine cause of a child's ADHD-like behavior, post-litigation conflict, alienation and indecision will continue to harm the child. When courts choose not to assign one caregiver as the medical/mental health decision-maker, it may make sense to assign a neutral, child-centered third party to mediate subsequent disputes and hopefully forestall future litigation.

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