An Adlerian Perspective on Children with Attention Deficit Hyperactivity Disorder

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Abstract

Children are creative in the ways they move through their world in an attempt to get their needs met. All living beings have a need to belong, to feel safe and significant which can be achieved in useful or useless ways. Children with Attention Deficit Hyperactivity Disorder are at risk for misbehavior that keeps them acting in ways that are not useful and do not promote social interest. A literature review was conducted to explore the Adlerian perspective of children with Attention Deficit Hyperactivity Disorder, and Adlerian approaches to promote social interest as an alternative view to the medical model for treatment. This author will look at the physiological underpinnings of Attention Deficit Hyperactivity Disorder as well as the issues surrounding emotion regulation, learning disabilities, co-occurring disorders, and behavioral manifestations of the disorder.
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An Adlerian Perspective on Children with Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder or ADHD is characterized by impulsivity, inattention and hyperactivity, but there is another side to ADHD that we do not see. Children struggling with symptoms of ADHD are at an increase risk for “elevated use and abuse of alcohol and heavier and earlier use of tobacco and other drugs by the teenage years (Molina & Pelham, 2003, p. 503)”. As of 2007, “parents of 2.7 million youth ages 4-17 years (66.3% of those with a current diagnosis) report that their child was receiving medication treatment for the disorder (CDC, 2013)”. Parents also report that children with a history of ADHD are almost “10 times as likely to have difficulties that interfere with friendships…and data from international samples suggest that young people with high levels of attentional difficulties are at greater risk of involvement in a motor vehicle crash, drinking and driving, and traffic violations (CDC, 2013)”. These same children are also struggling in school and in this author’s opinion, being set up for failure. About “20 to 30 percent of children with ADHD also have a learning disability (Martin, n.d.)”. On average, there are “1 to 3 children who have ADHD in every classroom of 30 students…the rate of emotional development for children with ADHD is 30% slower than their non-ADHD peers…25% of students with ADHD have other serious learning problems in one or more areas including oral expression, listening skills, reading comprehension, and math…and 40% of children who have ADHD have at least one parent who also has ADHD (Barkley, 2013)”. As quoted by Edwards & Gfroerer (2001), The National Institute of Mental Health reports “a higher incidence of children with ADHD in dropping out of school, smoking, abusing drugs or alcohol, and going to prison (p. 211)”. ADHD can affect every area of an individual’s life and as we learn more about the disorder, there is an even more sense of urgency to help the individuals involved. As we see the rates of ADHD increase, we will continue to see increases in
the way this disorder manifests itself in the lives of those it affects. This author will conduct a literature review of research surrounding ADHD as well as how Adlerian perspectives can be useful in helping this population so they can reach their full potential and achieve greater positive outcomes.

**DSM-5 Definition and Criteria for ADHD**

According to the American Psychiatric Association’s Diagnostic and Statistical Manual 5\(^{th}\) edition, in order to be given a formal diagnosis, a child must meet one or more criteria for the disorder with at least six or more symptoms persisting for six months or longer. The criteria are split into two sections: inattention and hyperactivity-impulsivity. The inattention section requires an individual to have at least five or more symptoms no less than six months that are “maladaptive and inconsistent with developmental level” (APA, 2013 b, p. 59).

Inattention symptoms are as follows:

(a) Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.

(b) Often has difficulty sustaining attention in tasks or play activities

(c) Often does not seem to listen when spoken to directly

(d) Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional defiant behavior or failure to understand instructions)

(e) Often has difficulty organizing tasks and activities

(f) Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) Often loses things necessary for tasks or activities (e.g. toys, school assignments, pencils, books, or tools)

(h) Is often easily distracted by extraneous stimuli

(i) Is often forgetful in daily activities

Hyperactivity-Impulsivity symptoms are as follows:

Hyperactivity

(a) Often fidgets with hands or feet or squirms in seat

(b) Often leaves seat in classroom or in other situations in which remaining seated is expected

(c) Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

(d) Often has difficulty playing or engaging in leisure activities quietly

(e) Is often “on the go” or often acts as if “driven by a motor”

(f) Often talks excessively

Impulsivity

(g) Often blurts out answers before questions have been completed

(h) Often has difficulty awaiting turn

(i) Often interrupts or intrudes on others (e.g. butts into conversations or games)

Individuals experiencing such symptoms may also have had hyperactive-impulsive or inattentive symptoms which caused impairment before the age of twelve. Individuals with ADHD also have impairment from the symptoms in two or more settings (e.g. school, work, or home) (p. 60). There also must be “clear evidence of clinically significant impairment in social, academic, or occupational functioning” and “do not occur exclusively during the course of a Pervasive
Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not accounted for by another mental disorder (e.g. Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder)”( p. 60). If an individual has met criteria for both inattention and hyperactivity/impulsivity, they are diagnosed as having “combined type” whereas if they meet criteria for one and not the other, the mental health professional giving the diagnosis is required to state which is more predominant, hyperactivity/impulsivity or inattention.

Individuals who do not meet criteria for ADHD but exhibit symptoms of the disorder may be given a diagnosis of “Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified”. An individual must exhibit clinically significant impairment, and present with inattention, and behavioral patterns marked by sluggishness, daydreaming, and hypoactivity (APA, 2013 b, p. 66).

In May 2013, the new DSM-5 was released and changes were made to the diagnostic criteria for ADHD. The following changes were presented and accepted into the new revision: “1) Examples have been added to the criterion items to facilitate application across the lifespan; 2) the cross-situational requirement has been strengthened to ‘several’ symptoms in each setting; 3) the onset criterion has been changed from ‘symptoms that caused impairment were present before age 7 years’ to ‘several inattentive or hyperactive-impulsive symptoms were present prior to age 12’; 4) subtypes have been replaced with presentation specifiers that map directly to the prior subtypes; 5) a comorbid diagnosis with autism spectrum disorder is now allowed; and 6) a symptom threshold change has been made for adults, to reflect their substantial evidence of clinically significant ADHD impairment, with the cutoff for ADHD of five symptoms, instead of six required for younger persons, both for inattention and for hyperactivity and impulsivity”(APA, 2013). The final change to the new DSM-5 places ADHD under the
“neurodevelopmental disorders chapter” to reflect brain developmental correlates with ADHD. This is due to the prevalence of children with ADHD experiencing, “mild delays in language, motor, or social development… [as well as] low frustration tolerance, irritability, and mood lability” (APA, 2013 b, p. 61). Professionals who are qualified to give an ADHD diagnosis are psychiatrists, psychologists, family care providers, certified nurse practitioners, master’s level counselors, master’s level social workers or licensed clinical social workers, as well as neurologists. Research is beginning to understand specific brain structures and neurotransmitters which may be involved in ADHD and can lead to more effective treatment options.

**Neurological differences in ADHD**

Executive functions are those mental control processes that enable self-control and goal-directed behavior; these functions are controlled by the prefrontal cortex and its extended networks (Oosterlaan, Logan, & Sergeant, 1998). A fundamental component of the executive functions is the ability to inhibit inappropriate responding. Halperin, McKay, Matier, & Sharma, (1994), as quoted by Barkley (1997) distinguish three forms of response inhibition: 1) inhibiting prepotent responses, 2) stopping an ongoing response, and 3) inhibiting interference. The goal of response inhibition is to enhance adaptive functioning. Abnormalities in response inhibition are a key component in the description and explanation of childhood ADHD. Barkley (1994, 1997) argues that ADHD involves a “pervasive deficit in all forms of response inhibition… [and] this deficit leads to secondary impairments in four executive functions that depend on efficient response inhibition for their execution: working memory, internalization of speech, self-regulation of affect-motivation-arousal, and reconstitution” (p. 68). As a result, children with ADHD present with impairments in executive functioning which most often leads to disturbances in self-control and goal directed behavior.
Gray’s neuropsychological model of brain functioning can be used to gain insight into the behavior of children with ADHD. Gray (1982) as referenced by Quay, (1998, b., 1997), refers to the activity of two opposing brain systems: the Behavioral Inhibition System or BIS, which is sensitive to signals of punishment, and the Behavioral Activation System or BAS, which is sensitive to signals of reward. The BIS’s function is to inhibit behavior whereas the BAS controls the initiation of behavior. Quay proposed that children with ADHD have persistently underactive BIS which results in response inhibition deficits. Barkley (1994, 1997) argues that this deficit is unique to ADHD. The race model of response inhibition states that response inhibition depends on a race between the process underlying response execution and the inhibitory process (Logan, 1994). This inhibitory process is triggered by information that tells the individual to stop or change a current action or behavior; the process that finishes first determines the outcome (Oosterlaan, Logan, & Sergeant, 1998). If the inhibitory process finishes first, the response is stopped or withheld; if the inhibitory process does not finish first, the response which is ongoing is completed. Individuals with an underactive BIS, may be less avoidant of situations which would be fearful to others, such as we see with risk-taking behaviors and difficulty in self-control.

The BIS is thought to be involved in anxiety; if an individual has a highly active BIS they will more than likely experience a heightened sensitivity to nonreward, punishment, and novel experience; they learn more through punishment than reward. In anxiety, individuals may avoid such environments to avoid negative experiences such as fear, sadness, and frustration. So, an underactive BIS in a child with ADHD may look like risk-taking behaviors and impulsivity whereas and overactive BIS may present more like an Anxiety disorder. The BAS in contrast is sensitive to reward and according to Gray “conditioned appealing stimuli” which helps to curb
impulsivity (Gray, 1987). Individuals with a highly active BAS experience more positive emotions and are more goal-achievement oriented; they learn better through reward than punishment.

The Behavioral Inhibition System has been shown to have a close correlation with serotonin and the Behavioral Activation System has been linked to dopamine levels in the brain. Dopamine is a neurotransmitter released by the brain and when in excess or deficiency can cause several disease conditions (Mandal, n.d.). The basal ganglia depends on a certain amount of dopamine to function at peak efficiency; if there is a deficiency in dopamine his could cause slowed reactions by influencing an indirect pathway whereas an overabundance of dopamine could increase actions in the direct pathway, which could result in impulsive action or excessive movement. Dopamine is also responsible for concentration and attention and is part of what stays in our short-term memory; it allows for us to send signals to the parts of the brain needed for memory. When free dopamine is reduced, it is thought to affect concentration and attention much like what is seen in ADHD. Dopamine in the frontal lobes of the brain controls the flow of information from other areas of the brain; when disordered, this region leads to declines in memory, attention, and problem solving which are also key deficits in individuals struggling with ADHD (Mandal, n.d.). Another important neurotransmitter, serotonin, helps relay messages from one area of the brain to another; because serotonin plays an important role in mood, it is thought that limited production of serotonin or suppression of serotonin is responsible for mental health conditions such as depression (Bouchez, 2013). This could also explain why individuals, who have highly active BIS, may experience more negative emotional states than others. Serotoninergic systems also contain key brain regions such as the basal ganglia which is important in the presentation of ADHD symptomology.
The basal ganglia is associated with motor control, cognition, emotions, and learning (Qiu et al., 2009). It is comprised of the caudate nucleus which includes the globus pallidus and putamen; together, the caudate nucleus and putamen make up the striatum. The caudate nucleus works with the putamen to receive input from the cerebral cortex and is the “entrance” to the basal ganglia. The putamen’s main function is to regulate movements and influence various types of learning. The globus pallidus requires input from the putamen and caudate and communicates with the subthalamic nucleus; it acts as a “highway” between other brain regions (Frodl & Skokauskas, 2012). The same authors found that children with ADHD have reduced right globus pallidus and putamen volumes as well as decreased bilateral caudate volumes. They suggest that children who remain untreated for ADHD would have additional structural changes in limbic regions like the amygdala and Anterior Cingulate Cortex. Researchers have suggested that the size and shape of the globus pallidus may play an even more crucial role in ADHD as multiple brain regions can be critically dependent on it. This seems to suggest that ADHD is more correlated with brain volume imbalances due to decreases of specific brain regions, specifically the putamen and globus pallidus. The basal ganglia region of an individual’s brain has often been found to be underactive in ADHD and overactive in Obsessive Compulsive disorder and Anxiety disorders (Nakao et al., 2011). As stated by Frodl & Skokauskas (2012) “mis-development” in the wiring process (such as seen in the formative years) may play a role in the onset of ADHD both directly and indirectly (by interaction with other key ‘ADHD’ brain regions).

The authors also believe a positive response to methylphenidate (Ritalin, Concerta, Daytrana) may be influenced by the function of the right putamen region. So, a functionally active right putamen brain region may increase the odds of a child being able to tolerate the
medication whereas children with reductions or abnormally slow developments of the right putamen may be less successful with this type of medication. As of now, it is unclear if this brain region exhibits the same effect on other stimulant medication. A metabolic study found individuals with ADHD had abnormally low ratios of N-acetylaspartate or NAA to Creatine which are often good indicators of neuronal health in several key brain structures (Courvoisie, et al., 2004). The study suggests supplements of Creatine could improve ADHD symptoms; however Creatine supplements have been used by exercise enthusiasts and have found to increase Creatine further which means it could exacerbate some of the negative effects of ADHD by interfering with the desired ratio of NAA to Creatine in the brain (EBlog, 2009).

New research has shown that dopamine helps regulate motivation which causes individuals to persevere to obtain something positive or avoid something negative (Salamone, 2012). The same research found that dopamine is released before and not after we take action and that it encourages physical movement. Individuals with ADHD who have decreased levels of dopamine as a result struggle with motivation to start a task because they lack the chemical components in the brain to do so. Medications such as methylphenidate and amphetamine have been shown to increase dopamine and norepinephrine levels in the brain. High levels of dopamine mean high levels of motor activity and “impulsive” behavior. Dopamine plays a role in reward which is why it is more associated with the Behavioral Activation System. Stimulant medications to treat ADHD are thought to block reuptake of norepinephrine and dopamine into the presynaptic neuron, therefore increasing the level of neurotransmitters in the brain (Meyers, 2013). Basically, Adderall (and other stimulant medications) bind dopamine and norepinephrine in the brain and epinephrin in the Adrenal Gland which floods the brain and leaves us feeling alert, euphoric and “ready to go”. Norepinephrine modulates the sympathetic nervous system,
which drives our “fight, flight, or freeze” response. So, the alertness an individual feels when in a heightened sense of arousal (fight, flight or freeze) coupled with epinephrine (or adrenaline) and dopamine (promotes feelings of pleasure) is what allows the individual to increase attention and concentration while feeling calm (less anxious) about stimuli in their environment. In some cases, high levels of dopamine already in the brain coupled with a medication that increases dopamine does lead to more hyperactivity and impulsivity; however for many it appears to balance the brain’s chemistry enough where we see a decrease in hyperactivity and an increase in attention and concentration. Researchers have yet to fully understand why we see variation in results when one medication is given to two different individuals presenting with similar symptoms of hyperactivity and impulsivity.

Stannard-Gromisch (2013), notes that while dopamine and norepinephrine are associated with reward processing, they are not associated with the emotional dysregulation seen in ADHD. The author continues to emphasize that serotonin has been found to be related with impulse control and aggression and it is from this same research that a genetic basis for this correlation has been found. Serotonin is important for managing mood, appetite, sleep, and dreaming. If serotonin levels become low, an individual may be irritable, anxious, depressed, and have difficulty sleeping; antidepressants that work to increase serotonin can have both a stimulant and sedative effect (TheDEA.org, 2013). Serotonin also helps control the flow of thoughts and information in [the] brain…when the serotonin is strong and active, thoughts flow in a fairly orderly and coherent manner. If serotonin levels decrease, thoughts can become more scattered and unfocused and memory and concentration may become more difficult. Research has also found that “impulse control, emotional regulation, and social functioning appear to be qualifiers of the violent behavior associated with serotonin dysfunction” (Krakowski, 2003, p. 294).
The same author conducted a literature review of serotonin, aggression and impulse control was conducted and found that “serotonin is seen as playing a role in the inhibition of impulses other than aggressive ones…strong emotional states often accompany violent acts that are considered impulsive… [and] irritability, temper outbursts, or a greater emotional responsiveness to others are often present in violent or impulsive individuals” (p. 295).

Interestingly, the same literature review found, “there is a high density of serotonin type 2 receptors in the prefrontal cortex, an area that has been implicated in aggressive and violent behavior…higher density of this receptor has been noted in the postmortem brain of suicide victims, especially in the prefrontal area” (p. 295). Serotonin imbalance appears to be accompanied by impulsivity or some form of emotional dysregulation. In the majority of studies that focused on violence and serotonin, many individuals also had personality disorders which could be an important factor but not the sole explanation for subsequent behavior. For example, in borderline personality disorder, both poor impulse control and emotional dysregulation are prominent features of the disorder and characterize the interactions with others. In conclusion, Krakowski found there is no “one-to-one relationship between serotonin and aggression, but rather a complex interplay among various factors” (p. 302).

Aggressive behavior is not as easily distinguished from the factors which contribute to its expression, however “serotonin affects psychological characteristics and social interactions that have an impact on violent behavior, while psychological and social factors exert an influence on serotonergic function” (p. 302). In a study using monkeys, the “dysfunctional aggression and impulsive behaviors associated with lower serotonergic function are accompanied by social dysfunction, poor social integration within the group, and lower social status” (p. 302). In the same study with monkeys, researchers found that “social status itself determines the extent to
which serotonin is an influencing factor...serotonin enhanced social affiliation more strongly in monkeys that were higher in dominant social status” (p. 303). Applying this to children with ADHD who have lower levels of serotonin, we would see more aggressive, impulsive behaviors such as noted in cases of Oppositional Defiant Disorder and Conduct Disorder.

Serotonin is made from a protein amino acid called tryptophan and in order to make serotonin from this we need a couple enzymes (Deans, 2011). First, tryptophan hydroxylase (with iron) converts tryptophan to 5-HTP, then a second enzyme makes 5-HTP into serotonin; there are two kinds of tryptophan hydroxylase (or TPH) (Deans, 2011). TPH1 is found in the periphery and pineal gland (which regulates sleep) and TPH-2 which is found in the neurons, and is where most of the work of creating serotonin from tryptophan is conducted. Serotonin can become melatonin which is why melatonin is at times administered for children with ADHD who struggle to fall asleep at bedtime. If a child with ADHD has lowered levels of serotonin, they may not be able to fall asleep due to the lack of serotonin converted into melatonin which is important for sleep. It has been found in animal experiments using mice, that serotonin is important in mice that are pregnant for the neural development of their offspring’s brain. If the pregnant mother experiences serotonin depletion, this can lead to dopamine depletion in their offspring which can cause inattention and impulsivity as has been discussed previously. Based on this evidence, we can assume ADHD has genetic components which is why it is passed on from generation to generation. The offspring of the pregnant mouse would experience lower levels of dopamine and serotonin which can lead to a presentation of ADHD symptoms. If this mouse were to become pregnant, their offspring too would then experience similar depletions and the cycle continues.
According to a research study in Norway, Norwegians ages 18 to 40 with clinically diagnosed ADHD were identified, as well as matched controls, and their families were sampled with special attention to the genes for TPH1 and TPH2 (Deans, 2011). The same authors found many mutations were found for the gene for TPH1…which is expressed in [the mother’s] reproductive parts and would be responsible for bathing the baby brain in serotonin. Based on their findings, mother’s with problems in serotonin had children more susceptible to ADHD as well as father’s with the same deficiency, however not as much as mother’s (Deans, 2011). This suggests the real issue occurs in brain development and maternal serotonin levels, much like with the experiments conducted with mice. Although a small sample size was taken, the authors report that mothers with TPH1 problems were more likely to “be smokers, drinkers, and drug users…as well as ‘prime candidates’ for schizophrenia, autism, and Tourette’s disorder in offspring.

**Emotion Regulation**

In understanding the ways neurotransmitter deficiencies are associated with presentation of symptoms of ADHD, it is not surprising that children with ADHD struggle with emotion regulation. As previously discussed, it is theorized that individuals with ADHD may have lower levels of dopamine and serotonin which could be attributed to the structure of the brain and therefore experience more negative emotional states, especially for children with ADHD who have difficulty regulating their emotions in healthy ways. For Example, a child with ADHD who acts impulsively, hyperactive in the classroom, and exhibits poor boundaries may experience social isolation from peers. Sciberras, Ohan, & Anderson (2012) states “the social difficulties experienced by children with ADHD are broad and include peer rejection or neglect, poor friendship stability and aggression” (p. 255). The child may begin to experience increased frustration with his or her inability to belong or connect with others and could lead to further
aggression. Lauth, Heubeck, & Mackowiak (2006) found that “students with ADHD problems were significantly more disruptive and inattentive” (p. 399) than students without a diagnosis of ADHD. In a longitudinal study of children with ADHD, Molina & Pelham (2003) found that “the presence of ADHD in childhood is associated with increased risk for elevated use and abuse of alcohol and heavier and earlier use of tobacco and other drugs by the teenage years” (p. 503). The same study also found that childhood ADHD symptoms, particularly the inattention dimension of ADHD, predicted later substance use than childhood antisocial behaviors, suggesting that “the severity of ADHD symptomology is uniquely important for the early emergence of substance use behaviors” (p. 503). The child grows into adolescence with continued frustration and may choose to cope with their situation by turning to alcohol or illegal substances and has the potential to cause legal problems. Caregivers of children who struggle with symptoms of ADHD attempt to provide them with healthy ways of coping with their negative emotions, however there are many factors which contribute to the development of the relationship between caregiver and child.

The parents or guardians of children with ADHD play an important role in helping them regulate their emotional states as well as understand them. We then see the importance of a secure attachment between parent and child and the impact this has on their ability to help their children cope with negative emotions. For example, a number of studies have found that “depressed mothers respond to their children’s emotions in ways reflecting their own preoccupation with sad affect, criticism, and helplessness which can distort their perceptions of the child’s feelings” (Waters, et al., 2010, p. 38). Researchers no longer ask whether or not depressed mothers exert a risk on child development; instead, they are looking at the pathways by which they affect the child. For example, “children of depressed parents may be genetically
predisposed to stronger physiological stress responses, and are thus more vulnerable to the environmental adversities often associated with parental depression” (Flykt et al., 2010). The same author also notes maternal prenatal depression is associated with harmful physiological effects on the fetus: elevated heart rate, increased physiological reactivity, delayed growth, prematurity and low birth weights have been reported. Research has also shown that newborns of depressed mothers show “biochemical and physiological profiles that parallel those of their depressed mothers, including higher cortisol levels and lower dopamine and serotonin levels” (Flykt et al., 2010). Interestingly enough, research has shown that children with ADHD tend to have lower birth weights as well as lower levels of dopamine and serotonin. This could be attributed to the difficulty of determining a clear diagnosis as ADHD, Depression, and Anxiety can look similar. As discussed previously, serotonin and dopamine play an important role in mood and etiology of depression and anxiety. Mothers who experience decreased levels of these two important neurotransmitters are more at-risk for depression which can have a negative effect prenatally as well as during the post-natal and other developmental years.

Attachment theory was developed by John Bowlby in 1969. His theory suggests that a central aspect of normal development is a bond between infant and caregiver that promotes the survival of the infant. Criteria for an attachment relationship include the following:

The bond is emotionally significant and persistent, involves proximity seeking, and takes place in a very specific fashion with a particular individual…the infant uses the attachment figure as a secure base from which to explore and seeks greater proximity under conditions of stress, danger, or novelty (Connors, 2011, p. 350).
Although physical proximity of infant to caregiver is important, it is not nearly as important as “felt security” as well as the caregiver’s accessibility and responsiveness (Connors, 2011, p. 350). It is not only important that the parent or guardian be aware of the child’s feelings, but also their own emotional state in reference to how they respond to their child. Research has also found that “parents who value the influence of emotions in their own experience, for example, and believe that they merit acceptance are more likely to be attentive to the feelings of their children” (Waters, et al., 2010, p. 39). So, it appears that helping children with ADHD regulate negative emotional states incorporates the child’s own knowledge of emotion, the parents own management of emotion, the willingness and openness to talking through situations with the child as well as the child’s willingness, and the presence of a secure attachment with their caregiver.

Waters and colleagues (2010) studied a sample of 73 mothers and their 4 ½ year-old children, and found that “the sensitivity of parental attributions of emotion to young children is important to their coaching of emotion regulation”. If a parent does not interpret their child’s emotional state correctly, the child may not have the knowledge to correctly “label” what they are experiencing and the parent’s own emotional experience may blend with their child’s which can leave the child confused. It is important for parents of children with ADHD to correctly identify the child’s emotion so that strategies to manage the specific emotion can be used. Research has found that, “parents face a greater challenge than is often assumed in supporting the development of competent skills of emotion regulation in young children because of the difficulty of accurately interpreting the child’s feelings in the immediate situation” (Waters et al., 2010, p. 45).
In the same study, authors found that children with secure attachments to their mothers were more likely to have a better understanding of negative emotions, a willingness to discuss situations where negative emotions arose, as well as mothers who were more aware of their own emotional state and how to manage negative emotions in healthy and productive ways (Waters et. al., 2010). They also found that mothers who felt that emotions play an important role in personal experience and are worthy of attention were more likely to attend to their child’s own emotional state with more care and appreciation. Children who have “greater comprehension of their feelings appear to be more competent at understanding, communicating, and conversing about those feelings with adults who can contribute further to their knowledge of and capacities for managing those emotions” (Waters et. al., 2010, p. 47). This is especially true for children experiencing negative emotional states which can be more perplexing and therefore need more attentiveness in healthy regulation strategies. Physiologically, it appears that children with ADHD may experience more negative emotional states under the assumption that they experience decreased levels of dopamine and serotonin in the brain. They are not yet able to cope with their various moods and so need parents or caregivers to coach them through and offer healthy ways of coping. As research has shown, a secure attachment to the caregiver is important in contributing to positive outcomes for the child.

Ainsworth (1978) as quoted by Connors (2011) found, children who develop an insecure attachment such as resistant or ambivalent manifested “great distress on separation and alternated between displays of anger and intense proximity seeking when reunited [most often] had mothers who were unpredictable, inconsistent, and insensitive, although they did show warmth at times” (p. 351). In avoidant attachments, infants show no reaction to a brief separation with their mothers and interacted with a stranger just as readily with their mothers (Connors, 2011). These
infants ignored their mothers on reunion, “busying themselves with toys” and the mothers were observed to be consistently “rebuffing and rejecting of their infants’ overtures, avoided physical contact, and withdrew from them when the infants showed distress” (p. 351). Although these were originally the two types of insecure attachments, a third has been more recently identified. This third style of insecure attachment is marked by incoherence and lack of organization of attachment behavior. These infants “freeze, appear disoriented, and display fear; such infant behavior has been linked to child maltreatment and unresolved trauma in a parent” (p. 351). Main and Hesse (1990), as cited by Connor (2011) proposed that “for these infants, the parent is both the source of security and the source of danger” (p. 351). Mothers of disorganized infants have been observed to behave in “alarming and punitive ways, arousing strong affect in their children but not alleviating it” (p. 351).

The author continues to write, “The infant or child actively organizes information concerning the attachment figure’s availability and regulates his or her behavior accordingly in order to optimize security” (p. 351). Securely attached infants are able to “use an attachment figure to help them modulate distress, insecurely attached infants must find ways to regulate affect in the absence of a secure bond to a sensitive other” (p. 351). In the case of avoidant attachments, infants whose mothers are continually rejecting, attempt to alleviate distress by minimizing displays of emotional upset as a way of adapting and maintaining an attachment bond versus the open expression of emotion. They do not see the use in open expression of emotion because they are continually rejected or criticized instead of validated. Ambivalent or resistant infant’s mothers are usually self-preoccupied and are only responsive sometimes to the needs of the infant. Ambivalent infants seem to “maximize affective display, showing intense neediness and emotionality in order to get through to a self-absorbed parent” whereas
disorganized infants “seem to lack any coherent strategy for managing frightening caregivers and overwhelming affects…” (p. 352). Such disorganization has been linked to aggression, dissociation, and over-controlling behaviors.

Bowlby (1969), as cited by Connors (2011) proposed that the infant gradually develops internal representations of the self as “worthy of care and attention (or not), and of others as trustworthy and available (or not), based on caregiving experiences” (p.352). For Attachment theorists, these “internal working models” are what guide future behavior. As children grow into adulthood, their attachment styles can be represented clinically in the mental health field. For example, “avoidant adults are prone to somatic disorders when under stress and have been found to use alcohol for tension relief, preoccupied status has been associated with suicide behavior and borderline personality disorder, and disorganized attachment is most clearly associated with dissociative disorders, criminal convictions, and violent behavior” (page 353). A child who is struggling with ADHD as well as having an insecure attachment with their caregiver puts them at-risk for physical, emotional, behavioral, and legal problems.

**Striving for Superiority**

Alfred Adler believed as human beings we begin life with feelings of being inferior. We are dependent upon our parents or caretakers to help us meet our needs for security, safety, belonging, as well as the necessities to sustain life. We form attachments to our caregivers as a way of adapting to our situation as weak and inferior. As Adler (1930) states, “…children when first born are weak, and their weakness makes it necessary for other persons to care for them…the style or the pattern of a child’s life cannot be understood without reference to the persons who look after him and who make up for his inferiority” (p. 59). He notes the importance of social relations in reference to feelings of inferiority and states “The weakness
which is responsible for the child’s living in a family group is paralleled by the weakness which drives men to live in society…All persons feel inadequate in certain situations…They feel overwhelmed by the difficulties of life and are incapable of meeting them single-handed…Hence one of the strongest tendencies in man has been to form groups in order that he may live as a member of a society and not as an isolated individual” (p. 60)”. Interestingly, he states, “Thus, we find that the beginning of social life lies in the weakness of the individual” (p. 61). For Adler, problems or difficulties we face as human beings are not just a problem for the individual, but also a social problem as we originally form social bonds out of our perceived inferiority. Therefore, from an Adlerian perspective, we can say ADHD can be looked at as a social problem. Continuing with this perspective, as discussed earlier, the ability for parents to correctly identify their child’s emotional state especially in reference to ADHD where moods tend to be disregulated, is an important factor in helping the child overcome their perceived inferiority and help them strive toward superiority. The opposite of inferior is superior which is why Adler believed as human beings we as a society strive to overcome our feelings of inadequacy. This also lays the groundwork for a secure attachment between infant and caregiver in that the child will feel safe to express their negative emotions, secure in the relationship with the caregiver, significant and as though they have a place in this world.

Children with ADHD also are often diagnosed as having behavioral disorders as well as Learning Disabilities. About “20 to 30 percent of children with ADHD also have a learning disability” (Martin, n.d.). Most often, children with ADHD have difficulty in the ways they learn, process, and express information needed for learning. Children with ADHD also struggle with peer relations as well as impulse control in school and at home. It is because of the problems these children are facing we can also conclude this is a social problem. Neurologically ADHD in
and of itself can cause behavioral or emotional problems. It also contributes to the
discouragement of children when their attempts to strive and overcome their inferiority are not
successful. As in what some research is suggesting, ADHD to have a genetic component to it,
Adler (1930) states if our “individual insufficiencies are inherited…It then becomes the aim of
psychology to train people to live well with others, in order to help decrease the effect of their
natural disabilities” (p. 61). In other words, ADHD interventions should also aim to teach skills
so that these individuals may live life as a fully engaged individual in their society versus
isolated due to inability.

Also, as previously stated, maternal depression (lowered levels of serotonin) can lead to
problems in neural development of the fetus and thus depression can be seen as a social problem
as well. Adler believed the symptoms are the solution the client has developed to solve their
problem, therefore, depression is seen as a solution to feeling inferior due to genetic deficiencies
or neurotransmitter depletion. For example, low energy, lack of motivation, negative affect,
suicidal ideation, and so on can be explained through decreased levels of dopamine and
serotonin, however as previous research has found, the extent to which serotonin is influenced
can be attributed to social status or degree to which an individual is accepted into a community.
So, the expression of depression could be due to an inability to “fit in” or belong which can
affect the extent serotonin is expressed in the brain and therefore presented in the form of
negative affect or depressed mood. In therapy, depressed clients are asked about their anger, as
many believed depression is “anger turned inward”. As previously discussed, this anger could
also be attributed to serotonin, but expressed in aggressive and impulsive ways. Women who are
experiencing depressed mood may have a chemical imbalance in the brain, however Adlerian
belief would suggest the depression serves a purpose, maybe to be excused from an inability to
live up to what life asks of them? If they struggle with ADHD, this may be even more apparent as society demands they conduct themselves in a certain way, however the biological makeup of their brain makes this difficult. The depression gives them an excuse not to have to deal with or tolerate their perceived inferiorities and therefore are excused from “dealing” with their children in appropriate ways. The depression acts as a way of distraction and avoidance from the lack of confidence and competence in being able to act in useful and socially interested ways.

Adler also emphasizes that children are creative in their ways of striving and therefore each individual is different yet striving for the same outcome. Because of this perceived inferiority, children with ADHD may seek ways to overcompensate for this and at times takes the form of misbehavior. Adler (1930) believed all behavior was purposeful and that we should “never criticize or punish mistakes in the style of life of the prototype” (p. 72). He stated when we meet an individual who is not socially interested, “we must remember, too, that he can be useful or useless and should therefore look carefully for the difference between useful and useless behavior” (p. 74). Children are creative in the ways they strive for superiority and attempt to obtain this in different ways. In looking at the four goals of mistaken behavior we see how a child struggling with ADHD may appear.

Rudolf Dreikurs (1964) proposed “Short-Range Goals of Misbehavior”. He believed that a child’s discouragement was a symptom of not being able to feel the “crucial C’s” which are: to connect, to feel capable, to count (be significant), and to have courage (p. 58). When children do not feel as though they are connecting with others in meaningful ways, they act out or misbehave in a way which leaves the adults feeling irritated and annoyed. These children seek attention and have a belief that they only count when they are being noticed (p. 59). For example, a child who continues to jump on a couch even after their parent has told them to stop may stop temporarily,
but continue after a few minutes. The adult feels irritated and annoyed while the child feels connected, so the child continues to do things (more likely unconsciously) in order to belong. If these children continue to feel as though they are not connecting, they may begin to engage in power struggles with the adults in their lives which leaves the adults feeling angry and challenged (p. 61). These children have now moved into feeling inadequate and believe that they should show the adults “who’s in control” and that they “can’t make me” do anything. An example would be a child who asks a parent to put their shoes on for them and the parent responds by saying the child can do it for themselves. If the child already feels as though they do not connect (or belong) in ways that leave them feeling secure, the child will engage in power struggles or what seems like control to “show” the adult they cannot make them do anything, even putting their shoes on their own feet. However, this can also be seen as the child’s way of gaining connection with the parent. When the attempt to connect with the parent is met with further discouragement (i.e. arguing, punishment for not completing the task, etc…), the child may begin to feel dependent or inadequate.

If a child continues to feel insecure and inadequate, they will begin feeling insignificant and seek revenge on the adults around them. These children feel as though they do not count and the adults in their lives impulsively seek to punish them for their revenge-seeking behaviors (p. 62-63). A child who is told to put their shoes on and they respond by protesting “no” (attention), the parent then may remind the child to put their shoes on and when the child again protests and whines that they want the parent to do it for them (power) and the parent continues to refuse they may emotionally and physically attempt to hurt the parent (revenge). To clarify, the goals of the child remain the same: to belong, feel safe, and be significant; it is the way they choose to obtain their need for connection that changes. For example, at this point, the child may say they hate
their parent or physically try to hit them to hurt them. The adult feels angry and challenged and moves to punish the child, which in response the child wishes to seek revenge on the parent even more than before. When children who reach this point now feel insecure, inadequate, and insignificant, they move to the belief that they cannot do anything right and therefore are hopeless and inferior. These children become avoidant and show displays of inadequacy (p. 63). Children with ADHD often exhibit behaviors which are aggressive and impulsive and can be applied to Dreikurs beliefs of the misbehaving child as a discouraged child.

The use of punishment may diminish the undesired behavior for a short period of time; however the child continues to respond by misbehaving in the future. Punishment does not breed cooperation, it breeds revenge and contributes to the power struggles parents involve themselves in with their children. For example, the adolescent who does not go to sleep at a time the parents feel appropriate; instead, he fights with the parents for control to assert his significance in the family and seeks revenge when further punishment of his continued defiance. The adolescent may seek revenge on the parents for the punishment in the form of verbal, emotional and at times physical abuse. In this case, the parents should collaborate with the child and come to an agreement on an appropriate bedtime. They may choose to allow the adolescent to choose what time he feels is appropriate for sleep under the condition that if he does not get up in the morning when he is expected and fulfill the daily routine expectations of the parents (shower, brush teeth, go to school on time) then the parents will get to choose the bedtime the next night. This removes the argument between parent and child who are engaging in a power struggle, while allowing the child to have confidence in their decision of when is appropriate to go to sleep. The adolescent will learn through logical consequences what time he needs to go to sleep in order to feel rested in the morning. The parents gain cooperation from their son and the son is able to
become more independent and confident in the decisions he makes for his own wellbeing. The home is less argumentative and the tension that was being fueled by the power struggle will begin to resolve. The adolescent may no longer seek revenge on the parents for feeling controlled and gains a greater sense of mutual respect as an active participant within the family.

To use our previous example, a child whose goal is to seek revenge on the parent continually, eventually leads the parents or guardian to “give up” or “give in” to the child because the child’s behavior has led the adult to feel despair and hopeless. The parent has made attempts to “fix” their child’s behavior and gain cooperation, but instead they have created an environment which only perpetuates the child’s mistaken beliefs of how they should go about getting their needs met.

Sometimes, the parent feels sorry for the child or allows the guilt they feel of “being a bad parent” rule the decision making process with their child. When a parent begins to feel sorry for a child this can be damaging as the child begins to mistrust their ability to move through the world in useful ways. The child then becomes aware of the parent’s despair, whether this is verbalized (“I don’t know what to do with you anymore”) or not (nonverbal communication where the adult walks away or allows the child to do what they please without correction). The child feels inferior and hopeless and begins to become passive, avoidant, and displays this inadequacy more frequently. This can look like a child who does not try in school because “what’s the point, I’m going to fail anyway” or “I can’t do anything right”. The child who believes they cannot do anything right will give up on attempts to engage in meaningful ways because their previous attempts to feel secure, competent, significant, and valued have been left unmet. It is children who reach this deepest level of discouragement who need the most encouragement. These are the children who become diagnosed with Oppositional Defiant
Disorder which is defined as “a pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms…” (APA, 2013 b, p. 462). As an added requirement for this particular diagnosis, symptoms must interfere in the functioning of school, home, or community (Martin, n.d.). Conduct disorder is also common and is defined as a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of at least three of the following 15 criteria [listed in the DSM-5] over the past 12 months and at least one criteria in the past 6 months (APA, 2013 b, p. 469).

It is interesting how many of the symptoms of these two disorders are similar to Dreikurs goals of misbehavior, especially with attention to power and revenge. As this author discussed earlier, Adler believed all behavior is purposeful and involves movement toward a goal. Therefore, we see behavior as movement from a felt minus (feelings of inferiority) to a perceived plus (superiority). Adler (1930) states in the case of “problem children”,

both the feeling of superiority and the feeling of inferiority exist on the useless side…such persons express a superiority complex as a compensation for their inferiority complex…the feeling of inferiority…exists in every human being, but this feeling becomes a complex only when it discourages him to the point of stimulating training on the useless side of life (p. 180).

When children misbehave, they are living life on the useless side in ways that are not socially interested as we see with Adlerian belief. Children who misbehave still feel superior as a way to compensate for their inferiority, however the ways they have chosen to move through the world
are useless and not helpful to society as a whole, which is why Adler refers to this as an 

inferiority complex.

Dreikurs (1964) writes, “encouragement is more important than any other aspect of child-
raising…it is so important that the lack of it can be considered the basic cause for misbehavior” (p. 36). He believed that a misbehaving child is a discouraged child. He continues to explain that 
children view adults as competent, “magically” capable, efficient, and large; children will 
“respond to their various predicaments with a tremendous desire to gain skills and to overcome 
the deep sense of their own smallness and inadequacy” (p. 36). For Dreikurs, adults get in the 
way of allowing children to build self-confidence and competence based on their own standards 
of what they feel is appropriate based on age. He states “…we confront them constantly with our prejudice –our doubt in their ability –and then justify this…” (p. 37). For example, parents may 
clear the table, clothe their children, put their shoes on, or “do it for them” because it’s easier, 
farmer, less messy, etc… Parents do not see this as discouragement, however when a child 

attempts to build self-confidence and competence in by creatively trying new ways to overcome 
obstacles is constantly being thwarted, this is what happens.

Take for example, a three-year-old who makes an attempt to clear their own plate from 
the dinner table only to drop it on the floor; the parent of the child may criticize the child for not 
being careful and being too little to do this on their own and to let the parent do it next time. This 
child becomes discouraged from taking responsibility and is excused from it because the parent 
does not have the confidence in the child to do it themselves. He states, “we must have it clear in 
our own minds that each ‘failure’ indicates only a lack of skill and in no way affects the value of 
the person…courage is found in one who can make a mistake and fail without feeling lowered in 
his self-esteem” (p. 38). It is a natural response to want to protect our children from their
Children with ADHD struggle with their perceived inferiorities and make attempts to strive for superiority in ways that are creative and allow for them to get their needs met. If we look at the four goals of misbehavior we often see the child with ADHD in all his discouragement. For example, a six-year-old who is easily distracted at school begins to be told by the teacher “pay attention”; with time, this continued prompt of “pay attention” may be interpreted as the child needs to put forth more effort. The child may “try harder” to pay attention with failed attempts which could lead to further discouragement and feelings of inadequacy and helplessness. The child may “give up” due to repeated failed attempts to please the adults around them. Because they do not feel as though they belong and are significant in a world that does not understand them, they seek other ways of getting their needs met which often is in the form of misbehavior. It is here we see Conduct Disorder and Oppositional Defiant Disorder which are further discouraging labels of how the child has failed. The school may respond by ways of expulsion or moving the child to another school that can meet the needs of the child. These are ways of sending messages to the child that the adults do not know what to do with him therefore we “give up”. This further creates feelings of inadequacy and helplessness. The child may also decide to attempt perfectionism as a way to compensate for their inferiority which could lead to further discouragement if they are unable to meet their own standards of “perfect”. The child who strives for perfectionism could begin to self-blame which directly relates to the idea “I am not good enough” and therefore directly affects the self-concept.
**Attention Deficit Hyperactivity Disorder is a Social Problem**

According to Adler (1930), “social maladjustments are caused by the social consequences of the sense of inferiority and the striving for superiority” (p. 215). He believed inferiority and superiority complexes are a result of the individual’s response to his or her social environment. Individuals, who do not suffer from such complexes, do so as a result of social interest, courage, and social mindedness or the logic of common sense. Adler continues to write that those who hide their feelings of inferiority may do so in ways that are not obvious, but can be seen in their private logic or beliefs they hold about themselves, others, and the world. There are others who express their feelings of inferiority openly and in doing so feel “greater than others because they have confessed while others cannot” (p. 217). These individuals hide their inferiority through a superiority complex, which serves as compensation. It is a “calling out” of sorts used as an excuse as to why the individual cannot obtain success therefore excusing them from responding to what life asks of them. For Adler, these individuals are living on the “useless side” of life and that we “arrange” our lives in such a way that creates feedback to support our beliefs of ourselves and our world. Regardless of the various creative ways children develop as a way of moving through their world, as they grow they are asked to take a stand on the issues of work, social, sex, self, and spirituality. While Adler’s original life tasks involved work, social relations, and sex, the other two were suggested later. He states that we are “obliged to respond” to these life tasks and we arrange ourselves in a way of being able to do so.

The work task involves cooperation with one another to “build a community in which we can thrive and grow...by ‘sharing’ work required to survive…” (Mosak & Maniaci, 1999, p. 99). We rely on others in our community to help build shelter, provide food and clothing, as well
as many others. Adler saw work as a way to contribute to the commonwealth which promotes social interest. The social task includes family and friends and comes from the idea that “we are too weak to live alone” and that “nature has given us the human community as the best weapon against extinction…” (p. 102). Without community and cooperation with one another we face extinction; we need one another to survive. The task of sex/intimacy is usually seen as fulfilling the need to procreate which is also a need for survival of human beings as a race. It is also what Adler believed to be the most difficult. Adler believed the sexual task involved constant cooperation and skill to fulfill as well as an understanding that the different genders were equal versus a societal view of men being strong and women being weak or inferior. The self task involves private logic about who I am in relation to the world. It incorporates personal beliefs, opinions, biases, prejudices as well as private beliefs of the world and how the world “should” function. The fifth task involves spirituality and incorporates the belief in something greater than ourselves, our feelings surrounding this and in relation to our families, communities, and self. It incorporates beliefs of life and death and our relationship to the universe. The self and spiritual tasks were later suggested after Alfred Adler had died and the Adlerian community continues to debate whether or not the two constitute the life tasks. Despite the controversy of which life tasks should be included, Adlerians agree each individual is asked to respond to the life tasks and they do so in useful and useless ways.

Adler believed social interest was an important part of living on the useful side of life because it promoted the well-being of others. As an example of self-interest, the case of a child who does not attempt to succeed in school seen as lazy by others, could be hiding feelings of inferiority and fears others seeing him as a failure. So, he “busies” teachers and parents by shifting their focus on his behavior (perceived laziness). This allows him to succeed in gaining
the attention of others, therefore avoiding facing the feelings of incompetence or failure, which in return creates a feeling of superiority over others. The child’s significance lies in gaining the attention of others through useless ways. This is maladaptive and self-interested. Adler (1930) believes in all cases of inferiority complexes, it is due to a lack of courage on the part of the individual and it is in this “lack of courage connected with an inferiority complex that ruins a person” (p. 226). He believed that children have inferiority complexes, but it is when these complexes are turned into a neurosis that they continue to obtain superiority as a way of compensation for the inferiority they feel. The child is “excused” from responding to the life tasks in useful ways that would promote social interest. Children who have “given up” and do not put forth effort may become “helpless” the caregivers of these children eventually give up on them as well stating “it’s no use, there is no point in asking anything of you”. This is what the child wanted in the first place, to be excused from engaging in life in useful ways because it puts them at-risk for failure which they want to avoid in order to protect their self image. Meaning, if a child’s goal is to never fail and to do things perfectly in life, attempts at being “perfect” may be met with failure, as we are imperfect beings. The child may then avoid situations such as completing homework, cooperating with the requests of mom and dad, because if they attempt to succeed, they have a mistaken belief they will fail. They may even have collected “evidence” for why they should never try in life by previous failed attempts at belonging and being significant in useful ways. They believe if they never try, they will not risk failing and therefore no one will see how inferior they feel about being able to respond to the tasks of life. They feel a sense of superiority in evading the tasks of life, however useless the behaviors may be.

Social interest or Gemeinschaftsgefühl, is a community feeling which is the “empathic, emotional bond we have with each other and our world” (Mosak & Maniacci, 1999, p. 113). As
Adler writes, it is a feeling; social interest is an action based upon the feeling of community, of a sense of belonging. If we live with a feeling of community, we will act in accordance as so. For example, we would act in ways that would not only benefit ourselves in this place and at this time, but also benefit others who may not yet be alive. As Mosak & Maniacci (1999) state, “if our feeling of community is strong, we take them into account in our actions and leave posterity a better world” (p. 113). Social interest is movement toward the betterment of all; it encompasses both a feeling of belonging as well as empathy and compassion for others. It is from this point of view that we can then conclude that ADHD is a social problem which involves the community as a whole. As mentioned earlier, on average, there are “1 to 3 children who have ADHD in every classroom of 30 students…the rate of emotional development for children with ADHD is 30% slower than their non-ADHD peers…25% of students with ADHD have other serious learning problems in one or more areas including oral expression, listening skills, reading comprehension, and math…and 40% of children who have ADHD have at least one parent who also has ADHD” (Barkley, 2013). As quoted by Edwards & Gfroerer (2001), The National Institute of Mental Health reports “a higher incidence of children with ADHD in dropping out of school, smoking, abusing drugs or alcohol, and going to prison” (p. 211).

According to new data, “11% of school-age children in the United States have received a medical diagnosis of ADHD…” (Schwarz & Cohen, 2013). Prevalence continues to rise as more individuals are being diagnosed and these statistics reflect the cases which have been diagnosed, often times ADHD goes undiagnosed. Ford, Goodman, and Meltzer (2003) conducted an epidemiological study as quoted in Lauth, Heubeck, and Mackowiak (2006) and found that “a diagnosis of ADHD may be missed altogether if information is not sought from teachers about children’s functioning in school” (p. 397). There is also mention of children being over
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diagnosed with ADHD which could be explained by the adults’ lack of tolerance for their child’s behavior and rush into medication management of symptoms versus behavioral or other interventions. As of 2007, “parents of 2.7 million youth ages 4-17 years (66.3% of those with a current diagnosis) report that their child was receiving medication treatment for the disorder” (CDC, 2013). Parents also reported that children with a history of ADHD were almost “10 times as likely to have difficulties that interfere with friendships…” and data from international samples suggest that young people with high levels of attentional difficulties are at greater risk of involvement in a motor vehicle crash, drinking and driving, and traffic violations. Criticism surrounding the medical community, argue doctors often do not focus on how the child with ADHD is coping, they tend to focus on weight, height, eating habits, and side effects of the medications they are prescribing. They are treating symptoms physiologically, without also taking into account the child’s perception of how they are functioning. Society attempts to respond to these “difficult” children with medication and behavior management strategies, but the solutions society introduces are the ones that are further discouraging the child. We, as a community, say “here is a box and you must fit inside this box” (control behavior) which can be done through medication. The attitudes society has toward children with ADHD are not encouraging them to live on the useful side of life. Although, such attitudes may appear to be socially interested, these views can also be seen as self-interested. Society wishes for these children to be productive, useful, and interested in progress, while the adults involved in these children’s lives also send messages that who they are is not enough. We wish to change them through medication or other interventions that can be damaging. We believe by “intervening” in these ways that we are helping them to be more socially interested, when in reality it is our own self-interest and fear of our children failing to respond to the life tasks. Parents and doctors tell
these children that if they take a pill, they will improve, however in doing so, can send the message that who you are is not good enough therefore we must “fix” you to become better. Children, because they view adults as more competent and efficient, believe in what they suggest as ways of coping; what then, does the child assume when the medication does not improve their “condition”?

A recent study of preschoolers published by the *Journal of the American Academy of Child and Adolescent Psychiatry*, showed “9 out of 10 young children with moderate to severe ADHD continue to experience serious to severe impairment long after their original diagnoses and treatment” (Nauert, 2013). The study was conducted at the Johns Hopkins Children’s Center and is the largest longitudinal analysis to date of preschoolers with ADHD. Nearly 90% of the 186 children who were followed in this study, continued to struggle with ADHD symptoms six years after their initial diagnosis and children taking medication had just as severe symptoms as those who were medication-free. Even more interesting, “62 percent of children taking anti-ADHD drugs had clinically significant hyperactivity and impulsivity, compared with 58 percent of those not taking medicines”. Researchers are unclear if the lack of progress was due to ineffectiveness of medication, poor adherence, suboptimal drug choice or other reasons. Also, children who had a co-occurring diagnosis of Oppositional Defiant Disorder or Conduct Disorder were “30 percent more likely to experience persistent ADHD symptoms six years after diagnosis, compared with children whose sole diagnosis was ADHD” (Nauert, 2013). However, we cannot assume based on this study alone that medication is ineffective altogether, but we can see how difficult it is to pinpoint which medication will be effective for that particular child. It is in this author’s opinion that medication management to treat ADHD is another way to compensate for
inferiority; it allows for these children to include themselves in society, however as this study has shown, medication may not be the answer.

In allowing children with ADHD to be hyperactive, creative, messy, disordered, sensitive, and emotional we allow them to have courage. It is possible encouragement has the potential to be more effective than medication itself. The adults that come into contact with children who have ADHD can also have courage to better tolerate children with such symptoms instead of rushing to medicate them. Children with ADHD will begin to love and accept the parts of themselves that are complicated and messy, instead of trying to change them. Society can accept them as imperfect while allowing them to practice courage by being authentic. The view that children who struggle with symptoms of ADHD as “misbehaving or troubled” children, is one our society has accepted, but as Adler (1930) states “the ideals of a nation may change –they may change suddenly, as after a revolution, or gradually, in the process of evolution” (p. 174).

The topic concerning the health and well-being of children with ADHD is changing as we are learning more through research and experience and with it our views of “what’s best” are continually shifting. It is impossible to protect children from every pain. The world is a “messy” one, full of challenges and obstacles. Children with ADHD need encouragement and support so they can be more secure in responding to the challenges life presents. Parents make difficult decisions in the treatment of the child who has ADHD such as whether or not to take a natural approach through dietary restrictions or mineral supplements or use medication knowing it may affect growth and physical development. In return, these parents and caregivers have a sense of inferiority relating to their child and the situation and would need continued support.

ADHD requires society to respond, especially since each child is different in the way their symptoms of ADHD are presented and affect the social context of their life. These same
children are the future of what tomorrow will bring; if we continue to produce children who are living on the useless side of life, community feeling will diminish and tragically, will continue to work against one another instead of with one another. Children with ADHD need unconditional love, support from all individuals involved in their lives, as well as encouragement. As Alfred Adler believed, we cannot assume a child is a “bad” child, we must first see what conclusion the child has drawn. We cannot assume a child will succeed or fail based on the progress they do or do not make set upon the standards of self-interested individuals. All behavior is purposeful, whether it is useful or not. The greater question being, is the way they have chosen to contribute and respond to life useful or useless? Does it promote the interest of others or hinder progress for self-interest? Are they sharing the feeling of community or isolating themselves for fear of rejection? Caregivers should remember that when incorporating new ways of encouraging children with ADHD, we are looking for improvement not perfection. Dreikurs emphasizes focusing on the strengths of the caregivers and building upon those strengths to reach improvement. Allowing for mistakes while not diminishing self-worth and being brave enough to try again. As caregivers, one can only encourage the child to behave in useful ways; it is still ultimately up to the child to decide what they will do. They could continue to get their needs met and gain a sense of significance and belonging through useless ways, however the adults need to set the consequences if the choice to continue is made. Children’s cooperation can be gained through mutual respect as well as boundaries which establish the family values. As children grow to teenagers, they will push and explore their external world, testing the adults in their lives. It is the responsibility of such adults to set limits which are mutually respectful while allowing the teenager to continue to explore, make mistakes, and develop their own sense of identity.
With regard to child-rearing practices, we must also understand the difference between discipline and punishment. Dreikurs (1964) writes, “no amount of punishment will bring about lasting submission…today’s children are willing to take any amount of punishment in order to assert their ‘rights’” (p. 69). At best, parents who punish their children in attempts to gain submission only gain their submission for short periods of time; they never gain the child’s cooperation nor do they encourage the child to act in ways that are useful. He states “even though children are no longer in an inferior position, they are untrained and inexperienced … They need our leadership” (p. 70). Children will accept our guidance if they know we respect them as equal human beings with equal rights to decide what they will do. Parents can learn to use more effective methods to “train” their children so they are willing to conform to the demands of order. Children with ADHD especially need guidance and need to see the parent role as imperfect as well. When parents allow for their own humanness to show, admitting fault when appropriate, and displaying imperfection, allows for the child to do the same. We allow for logical consequences to take effect; which provides an honest and real learning situation. Dreikurs writes to use caution when using consequences to gain cooperation; once consequences become a threat, they become punishment. At times, children with ADHD will misbehave as a way of gaining attention and significance in the world. They are aware of how they are “different” because their world reminds them of this, punishment of hyperactive behavior may only perpetuate the misbehavior and move the child away from cooperation and mutual respect. The child may seek revenge (as discussed previously) and as a result, the parents respond with more punishment to gain submission. This directly affects children’s self-image as well as their sense of belonging. Safeguarding can become a part of the person’s logic as he seeks to compensate for inferiority feelings; an individual’s private logic can be viewed in terms of
psychophysiology. It appears, while out of the awareness of the individual, the behavior and goals of the individual are a result of their physiology. As stated previously, all behavior is purposeful. Children misbehave because they believe it is the way they should act in order to belong. This may happen out of the child’s awareness, but also can be as a result of the differences in individual physiology.

Future research should focus on the impact of discouragement on the child with ADHD as well as using encouragement to gain cooperation. Research should also continue to understand the way the structure of the brain and neurotransmitters play a role in the etiology of ADHD prenatally as well as throughout the lifespan. Next steps can also include whether brain abnormalities correlated with symptoms of ADHD and can predict certain behavioral features. Also, the effectiveness of natural remedies to treat ADHD should continue to be explored in children. Adlerian approaches to child-rearing should also be explored in reference to ADHD and how to incorporate the knowledge researchers have found medically with the knowledge we have of Adlerian theory. The educational system should continue to seek evidence for improvement in utilizing Adlerian theory in their day-to-day operation. Resistance to such changes necessary to improve the quality of life for these children and therefore improve the way they contribute to society, is damaging. It is in this writer’s opinion that in the United States we do not acknowledge the importance of children and our responsibility that we have to them as a whole. As an example, due to budget deficits, Head Start programs were cut and many young children were left unable to attend school. As Adler believed, school is where we first begin to see the way the child’s way of being is expressed in a social context. It is also in this writer’s opinion that by cutting funding to programs such as Head Start we are unknowingly sending the message that our children are not important to us as a society and that message gets passed down
to the children, even if nonverbally. Children need structure and if we remove the important aspects of this structure to help guide them to become productive, socially interested individuals, we cannot argue the fault of the parents; we must take responsibility as a society in the raising of children.

**Conclusion**

In conclusion, children need encouragement like plants need water. Classical Adlerian belief would fail to recognize ADHD as a true illness, but as organ inferiority where the symptoms of ADHD are the solution to the individual’s problem. The problem being they make attempts to belong, be significant, and have a sense of security and are met with rejection, punishment, continued reinforcement of worthlessness. The subjective experience of each individual with ADHD is different because it incorporates their own unique way of moving through and navigating through the world. Behavior is influenced by attempts to overcome feelings of being inferior and at times these “ways of being” in the world are useless. We see this in the case of individuals who have been diagnosed with Conduct Disorder or Oppositional Defiant Disorder or from the perspective of Dreikurs, engaging in power struggles and seeking revenge. When we become aware of the child’s mistaken goal, we are better prepared to accommodate our response so that they may develop into socially interested beings. Adjusting our perception of ADHD as illness allows for acceptance of the child as they are. Medication management may improve symptoms, however it is still a form of compensation for inferiority, a way of safeguarding how inferior they feel due to the variation in brain functioning. Children need to practice courage and can do so only when the caregivers allow for it. We are imperfect and to act as though we are not further damages our authenticity. We damage our authenticity when we deny or avoid acknowledging the idea that we are all imperfect beings making attempts
to belong, be significant and feel secure. As society as a whole, we strive for superiority and we do so, at the expense of our authenticity at times. For some individuals, illness or disease is seen as “bad” therefore, in believing ADHD to be an illness, children begin to see themselves as “bad” or that there is something wrong with them. Instead of focusing on the strengths they do possess, children focus on their perceived weaknesses and some choose to avoid the life tasks or overcompensate for their feelings of inferiority to avoid being “bad”. Children may choose to avoid schoolwork for further examples of how they are a failure or “bad”, especially young children (5 or 6 years of age) where we see symptoms of ADHD begin to manifest.

ADHD may stem from depletion of maternal serotonin during pregnancy and can develop into a social issue which originates with feelings of inferiority. The chemical imbalance in the brain or underdevelopment of certain brain structures (as seen in the basal ganglia) can be looked at as an organ inferiority which is brought into the child’s awareness, more often than not, when they reach school age. This awareness can act as feedback from peers, teachers, and parents as well as the child’s own perception of their abilities. This is why looking at the educational system as a starting point for the treatment of ADHD is important; it is where mental health professionals, educators, and parents alike first see manifestation of symptoms. With prevalence increasing, children with ADHD need guidance toward prosocial or useful ways that work toward improvement. Research should continue to understand the child who has ADHD in reference to the social context which is where we see the result of such deficits. Resistance to the change needed to help these kids has the potential to further damage the potential they bring as well as what they can offer to society.
References


