ADHD and trauma
are they related?

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Some basic points

• Similarities between ADHD and a traumatised state
• Early attachment and brain state – the brain is partly ‘socially constructed’
• The ADHD temperament places considerable demands and challenges for the early attachment relationship
• People with ADHD have enhanced needs for empathic regulatory responsiveness from others (Kohut’s selfobject) – being precipitated into panic or rage (states of fragmentation) when this is absent
• The angry and out of control ADHD child may provoke counter-aggression from the caregiver – leading to a malignant spiral of negative interaction
• People with ADHD may encounter more traumas and adverse events because of their hyperactivity, impulsiveness, aggression – accident-prone
Structure of this presentation

• ADHD as a condition of impaired ego functioning – predisposing towards trauma
• The nature of ego function impairment in ADHD
• Some of general effects of trauma are similar to the characteristics of ADHD
• Adverse childhood events correlate with behaviours that are also characteristic of ADHD
• Both ADHD and trauma states require ego assistance
Succinct conceptual descriptions of ADHD

At the neurobiological level
• ADHD is a range of atypical features in the circuitry affecting the frontal lobes.

At the psychological level
• ADHD is a range of conditions of enhanced need for ‘selfobject’ (Kohut, 1971; 1977) responsiveness from others, to assist in the management of arousal, mood, impulse, and the relationship with the external world.

Within a Freudian psychoanalytic framework:
• ADHD reflects a ‘weak ego’ and comprises a general and pervasive deficit in ego functions
Impaired ego functions

- Difficulties with impulse control
- Tolerance of frustration and delay
- Regulation of affect
- Registering danger – developing ‘signal anxiety’
- Forward planning – working towards future goals
- Acceptance of reality – the Freudian ‘Reality Principle’ vs ‘Pleasure Principle’
- From ‘primary process’ to ‘secondary process’ thinking – proliferation of ‘beta elements’
- Taking account of other people
- Transforming primitive narcissism
Impact of impaired ego functions

• Impaired ego functions render the person with ADHD more prone to trauma
• More prone to maladaptive attempts at regulation (drugs, alcohol, stimulation-seeking)
• Less able to register danger and take steps to avoid it
• And less able to cope with and recover from trauma
• Trauma (by definition) overwhelms the ego and further impairs ego functions
The pervasive ADHD ‘No!’

• In normal development, the superego, as an internalised regulatory agency, has an important stabilising effect, enabling greater independence of the individual since prohibitions that were once provided externally are now established internally.

• This seems not to happen with (some) people with ADHD. Rather than taking in an external authority there is a continual expulsion of all prohibitory intrusions – which in children can, at times, almost take the form of a prolonged scream of ‘No!’.
ADHD grandiosity

• For the person with ADHD, their narcissistic grandiosity functions like another intense and peremptory instinctual demand

• In severe cases, the person cannot contain the pressures for expression of aggression, for seizing of immediate pleasure, and the assertion of grandiose self-importance and desires to be admired

• Their narcissism retains an overwhelming and forceful quality, that can be painful both for others and the person who is helplessly driven by these opprobrium-evoking and potentially shame-inducing needs.
A proliferation of ‘beta elements’

- Applying psychoanalyst Wilfred R Bion’s notion of ‘beta elements’ – raw sensory and emotional data, unsuitable for thinking unless transformed by ‘alpha function’.

- The primitive mind attempts to expel these – as if the mind were a muscle.

- ADHD states of impulsivity and rage.

- The person with ADHD may feel persecuted by the beta element contents of the mind – may feel terrified by long dreams of being hunted or pursued

Beta element states of mind

• “If the patient cannot ‘think’ with his thoughts, that is to say that he has thoughts but lacks the apparatus of ‘thinking’ which enables him to use his thoughts ... the first result is an intensification of frustration ...”

• **Bion, W.R. *Learning from Experience*. 1962 p 84.

• Whilst Bion was writing about psychotic processes, his observations and ideas have relevance to ADHD and other ‘beta element’ states of mind.
ADHD and related autistic spectrum conditions reflect states of impaired self-regulation – and of enhanced need for regulatory assistance from other people.

In Kohutian terms (Kohut, 1971; 1977), these others are experienced as selfobjects – meaning that psychological functions, of empathy, soothing, recognition and encouragement, that are provided by the other person (or ‘object’, in traditional psychoanalytic terminology), form part of the regulatory system of the self.
Both ADHD and repeated childhood trauma can result in the following:

- De-fusion of the aggressive and libidinal drives
- A dysfunctional superego
- Disruptions of attachment and deficits in the interpersonal regulation of affect
- Deficient use of signal anxiety
- Impaired capacity to relate to others
- Narcissistic disturbance – low self-esteem, combined with grandiosity and attitudes of entitlement
- Dissociation
Mutilated states of consciousness in people repeatedly traumatised in childhood

- Narrowing of consciousness – limited capacity to reflect
- Hypervigilance & hyperarousal
- Switched off – emotionally numbed – trance-like
- Hallucinatory internal voices
- Internal controllers
- Paranoid perceptions of others
- No expectation of being understood empathically
- Absence of transitional space – fantasy and hallucination are experienced as real.
- Inability to introspect
- Impaired sense of reality
- Rapid and unpredictable alterations in mood and behavioural state.
- Shifting identities
- Active struggle to avoid thinking about traumatic events
- Can be traumatised by a psychotherapeutic consultation.
Differences in presentation between ADD and traumatised states

• The traumatised person may show much more fear and distrust
• Marked distrust may be apparent in the transference
• Can be difficult to disentangle because having ADHD can lead to repeated traumas
• But trauma treatment does not resolve the core problem of ADHD if this is part of the neurobiological temperament
Adverse childhood events more prevalent in the background of children diagnosed with ADHD

Nicole Brown et al. 2014 Pediatric Academic Societies annual meeting Vancouver. 6th May.

• 65,680 children ages 6-17 years whose parents answered questions regarding ADHD diagnosis, severity and medication use as well as nine adverse childhood experiences (ACEs): poverty, divorce, death of a parent/guardian, domestic violence, neighborhood violence, substance abuse, incarceration, familial mental illness and discrimination

• About 12 percent of the children were diagnosed with ADHD. Their parents reported a higher prevalence of all of the adverse events than parents of children without ADHD

• Children dealing with four or more adverse experiences were almost three times more likely to use ADHD medications compared to children with three or fewer adverse experiences. Children with four or more adverse experiences also were more likely to have a parent rate their ADHD as moderate to severe compared to children with three or fewer ACEs

• Inattention, hyperactivity, and impulsivity may mirror the effects of childhood adversity – but such people may not respond well to stimulant medication
If a child with ADHD is seen in a family context, there is a common and understandable, but nevertheless misguided, tendency to view the problem as arising from inadequate boundary setting and structure. It is thus seen as reflecting family dynamics.

In many years of clinical practice within the NHS I have often found that young adults with ADHD, and their families, have been given a disservice through a failure to appreciate the nature and causes of ADHD, actually adding to the family’s despair and feelings of guilt.
Family interactions – the malignant escalation

• A child who is prone to rage, seemingly ‘strong willed’, who does not respond ‘normally’ to typical sanctions and socialisation. When thwarted the child becomes more enraged. He or she seems to seek out confrontations.

• The child is hyperactive – does not sleep - wants everything he/she sees.

• The child becomes estranged from peers and internally from the family

• The parents do not understand why the child is ‘naughty’ and is criticised by teachers

• Parents become chronically exhausted, frustrated, angry, and despairing – and guilty.

• Parental criticism and punishment evokes more rage in the child, whose self-esteem plummets relentlessly.

• Parental helplessness – and adaptation to the child’s temperament – are misperceived by others as the cause of the problem
Adverse Childhood Experiences Study (ACE)

• Persons who had experienced 4 or more episodes showed:
  • 4-12 fold increase in risk for alcoholism, substance abuse, depression, and suicide attempts
  • 2-4 fold increase in risk for smoking and poor self-rated health – and to have at least 50 sexual partners – and STD
  • The researchers found a graded relationship between number of childhood exposures and each of the risk behaviours and health conditions
The ACE (Adverse Childhood Experience) Study
Conducted by the US Center for Disease Control & Kaiser Permanente
17,000 PARTICIPANTS SURVEYED

Female Participants:
13% emotional abuse
27% physical abuse
24.7% sexual abuse

Male Participants:
7.6% emotional abuse
29.9% physical abuse
16% sexual abuse

The ACE Study Findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States.

It is critical to understand how some of the worst health and social problems in our nation can arise as a consequence of adverse childhood experiences.

Realizing these connections is likely to improve efforts towards prevention and recovery.
ACE Score and the Risk of *Perpetrating* Domestic Violence

Risk of Perpetration (%)

- Women
- Men

ACE Score

- 0
- 1
- 2
- 3
- 4
- >5

Risk of Perpetration (%)

- 0
- 5
- 10
- 15
ACE Score and Indicators of Impaired Worker Performance

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<th>Indicator</th>
<th>Prevalence of Impaired Performance (%)</th>
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<td>Absenteeism (&gt;2 days/month)</td>
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</tr>
<tr>
<td>Serious Financial Problems</td>
<td>10</td>
</tr>
<tr>
<td>Serious Problems Performing job</td>
<td>20</td>
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ACE STUDY FINDINGS
As ACE score goes up, so does risk for:

- **Health-risk Behaviors**
  - Sexual promiscuity
  - Sexual perpetration
  - Alcohol abuse
  - Illicit/injected drug use
  - Smoking

- **Mental health and well-being**
  - Depression, post-traumatic stress disorder (PTSD)
  - Aggression
  - Anxiety
  - Somatic complaints
  - Attempted suicide
  - Social ostracism
  - Anxiety
  - Academic achievement
  - Re-victimization
  - Unwanted pregnancy
  - Job problems; lost time from work

- **Disease and Injury**
  - STDs, including HIV
  - Gynecological problems
  - Heart disease
  - Diabetes
  - Stroke
  - Cancer
  - Suicide
Allan Schore – the relational aspects of the developing brain – interpersonal neurobiology

• “the self-organization of the developing brain occurs in the context of a relationship with another self, another brain” [p 389]

• “At the most fundamental level, the right brain attachment mechanism is expressed as interactive regulation of affective-autonomic arousal, and thereby the interpersonal regulation of biological synchronicity between and within organisms. During dyadic attachment transactions, the sensitive primary caregiver implicitly attends to, perceives (recognizes), appraises, and regulates nonverbal expressions of the infant’s more and more intense states of positive and negative affective arousal. Via these communications, the mother regulates the infant’s postnatally developing central and autonomic nervous systems. In this cocreated dialogue, the “good enough” mother and her infant coconstruct multiple cycles of both “affect synchrony” that up-regulates positive affect (e.g., joy–elation, interest–excitement) and “rupture and repair” that down-regulates negative affect (e.g., fear–terror, sadness–depression, shame). Internal representations of attachment experiences are imprinted in right-lateralized implicit–procedural memory as an internal working model that encodes nonconscious strategies of affect regulation”
By contrast – the relational growth-inhibiting attachment trauma

• “In marked contrast to the earlier described optimal growth-facilitating attachment scenario, in a relational growth-inhibiting early environment of attachment trauma (abuse and/or neglect), the primary caregiver of an insecure disorganized–disoriented infant induces traumatic states of enduring negative affect in the child”
Schore on the traumatising, mis-attuned, or neglectful caregiver

• “This caregiver is too frequently emotionally inaccessible and reacts to her infant’s expressions of stressful affects inconsistently and inappropriately (massive intrusiveness or massive disengagement), and therefore shows minimal or unpredictable participation in the relational arousal-regulating processes. Instead of modulating she induces extreme levels of stressful stimulation and arousal, very high in abuse and/or very low in neglect. Because she provides little interactive repair, the infant’s intense negative affective states are long lasting.” [p 390]
In the case of both ADHD and repeated interpersonal trauma, the following therapeutic tasks can be relevant:

• Providing a calm, empathic, and thoughtful presence
• Finding words and speech for impulse and affect
• Promote fusion of the drives through selfobject attachment
• Exploration of how projection of aggression and egocentric relating colours the perception of others
• Encouraging dominance of the ‘reality principle’
• Supporting strategies of sublimation
• Supporting the function of signal anxiety
• Tactfully countering grandiosity
• Facilitating a functioning superego
• Acknowledging positive aspects and achievements
Simple summary

- ADHD and trauma interact and mutually reinforce each other.
- The child and adult with ADHD may be more prone to trauma.
- His or her temperament may elicit traumatising reactions from others.
- The ADHD mind is less able to cope with, and recover from, trauma.
- ADHD and the traumatised state are both conditions in which the ego is overwhelmed and underperforming.
- Trauma and stress will inevitably exacerbate ADHD.
- In both cases, the psychotherapeutic task is to assist the ego in its management of internal and external demands.