

Chapter 1

[*The Disintegrating Self: Psychotherapy with Adult ADHD, Autistic Spectrum, and Somato-psychic conditions* By Phil Mollon. Published by Karnac. 2015]

Why this book was written - and why ADHD and autistic spectrum conditions are of interest to a psychotherapist

This book has been germinating for many years. It expresses my understanding of a variety of psychotherapeutic clients whose experience is of disintegration, or the dread of disintegration. I hope it will be of interest and assistance to those psychotherapists who, like me, remain puzzled and curious about the problems our patients and clients present, and dissatisfied with the help offered by prevailing paradigms. It is perhaps an attempt at reparation for the lack of understanding I have no doubt shown, in times past, towards many clients when, in accord with prevailing assumptions and attitudes within the mental health professions, I may have placed too much faith in the *dynamics of the psyche alone* - as opposed to the *psyche in relation to the brain and body*.

I feel a certain urgency in what I hope to convey, since I suspect my state of ignorance may have been shared by many colleagues. Long clinical experience, within the NHS and privately, tells me that ADHD and related conditions (including those on the autistic spectrum), particularly in adults, are not generally well understood or even recognised. It is a subject I feel is vitally important to psychotherapists, for the following reasons:

- Many psychotherapists have clients/patients with ADHD or autistic spectrum conditions, without realising this is the case
- ADHD and the autistic spectrum are vivid examples of the interplay of the neurobiological and the psychological – and of how both perspectives are needed for a more complete understanding, each informing the other (Solms & Turnbull, 2002)
- There is a neurobiological impairment – which then interacts with the family, school, and social environment to create the problems the adult later presents
- Multiple psychological traumas result from the interaction of temperament and environment
- There are profound impacts on self-esteem, self-image, and confidence
- People with ADHD and autistic spectrum traits have a vulnerability to panic, anxiety states, depression, and personality disorders

Adults with ADHD, unless they have been diagnosed in childhood, do not understand what is wrong. Years of difficulty, perhaps helped only minimally by doctors, psychiatrists, psychotherapists or other mental health professionals, may have left the person battered and wounded deeply in their self-esteem. In brief:

- They know they cannot manage many ordinary aspects of life
- They know they tend to be disorganised, forgetful, late, and erratic

- They know they get bored easily and find this aversive
- They know they can be impulsive
- They know they get into fights and arguments
- They know they often experience life as tedious, painful, frustrating and unrewarding – and feel restless
- They know they can feel depressed and anxious
- *They do not know they have ADHD!*

Attention Deficit Hyperactivity Disorder, along with the autistic spectrum problems that are often associated, are common amongst clients seeking psychotherapeutic help – but the therapists they are seeing (of whatever variety) usually do not know this either! Most psychotherapists, psychoanalysts, psychologists, psychiatrists, CBT practitioners, and counsellors appear to have little or no understanding of these conditions. The results are frustration and puzzlement for the therapist, and less than optimum help for the client.

Too often, it is assumed that ADHD affects mainly attention, or perhaps levels of activity (as indeed the name suggests). Even worse is the common misperception that a person does not have ADHD if he or she is able *sometimes* to concentrate and focus when something is of interest. The capacity for *hyperfocus* coexists with attentional impairments in ADHD. In fact, ADHD affects almost every area of psychological functioning, deeply compromising relationships, career, health, and general level of happiness and satisfaction in life.

Typical ADHD traits of hyperactivity, impulsivity, proneness to rage, difficulty in taking in information, seeming ‘not quite there’, egocentricity, low self-esteem combined with grandiosity, hypersensitivity and general narcissistic vulnerability, addictive tendencies, or unusual rigidity of thought and attitudes, may create bewilderment in the therapist. The client may be viewed as odd, difficult to engage, or as suffering from a ‘borderline’ or even an ‘antisocial’ personality disorder. Indeed, ADHD is often a hidden core within the clinical picture seen as Borderline Personality Disorder.

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. When I have spoken to them of the myriad expressions of ADHD and how these are all related, and the effects of these on both the person with the condition and their family, there has been great relief – and the exclamation “At last, someone understands!”

People with ADHD and autistic spectrum (Asperger) traits can benefit from psychotherapy, but do so more slowly and with more difficulty than others. There is a neurobiological basis to these problems, which gives rise to a variety of manifest behaviours, attitudes, anxieties, emotional states, and modes of cognitive

processing. This does not mean, however, that pharmacotherapy is the only feasible option. After all, mental states and processes and behaviours *always* have a neurobiological basis, but we still attempt to help people *psychologically*, which in turn will be expressed in neurobiological changes. The important point is to understand something of how the client's brain works, the advantages and disadvantages of their processing style, and the emotional states he or she struggles with. Without this understanding, neither client nor therapist are likely to arrive at a helpful perspective that can facilitate positive changeⁱ.

Impaired ego functions

Within the ADHD and associated autistic spectrums, people feel in continual danger of a state of *disintegration*. They have a particular need for the organising, stimulating, and regulating, empathic responsiveness of other people. When this is absent, they experience their mental world as falling apart, unable to think, plan, or focus. One result is rage (perhaps turned on the self), and another is addictive searching for stimulation. Shame, potentially overwhelming, is a constant threat. Where autistic traits predominate, the result may be a turning away from others, seeking comfort and security in inanimate objects or repetitive activities. In understanding and addressing these deficits in self-regulation, the dread of disintegration, and the associated need for empathic responses from others, the perspective offered by Kohut (1971; 1977; 1981) provides much illumination (Mollon, 2001).

People with these traits have impaired ego functioning. The Freudian concept of the ego, as the management of the interface between inner needs and external reality, provides a simple but theoretically potent framework that can embrace many different therapeutic approaches. It is also particularly helpful in understanding and addressing ADHD and related conditions. The traditional psychoanalytic focus on the nature of the 'instinctual drives', their fusion and defusion, aim-inhibition and sublimation, also turns out to be highly relevant. Similarly a psychoanalytic recognition of the rejection of the oedipal position, expulsion of the potential superego, and foreclosure of the Lacanian 'law of the father' is crucial to understanding certain aspects of ADHD.

Although, in certain respects, capable at times of a high level of relatedness to others, people with ADHD and autistic spectrum traits have impairments in their perception of others, tending to view other people egocentrically as 'need satisfying objects' rather than as individuals in their own right – and as 'coming alive' when needed, and fading out of psychic view when the need is gone. Another way of expressing this is to say that others are viewed solely in terms of their (Kohutian) *selfobject* function of providing empathy and other regulatory responses to distress. This is not an absolute trait, however. It may vary greatly from person to person, and also according to the person's own level of regulatory well-being at any one time.

An understanding of the neurobiological basis of the impairments in ego function is important. Without this, the client may be viewed merely as operating at the level of primitive mechanisms of defence. With knowledge of the neurobiological basis of ADHD and autistic spectrum conditions, it becomes possible for the psychotherapist to be much more empathic and appropriately supportive, and to alleviate the client's chronically impaired self-esteem and pervasive feelings of shame. Acknowledging

the positive features of these conditions, that may be adaptive in certain contexts, is also important in supporting self-esteem.

Selfobject disorders – dread of helpless disintegration

It is the main thesis of this book that 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*. In his important work, Allan Schore (1994; 2003; 2011) has explored in detail the neurobiological and interpersonal components of the selfobject functions.

This is rather similar to Winnicott's concept of the 'environment mother' (Girard, 2010; Winnicott, 1955; 1960). In the beginning, the infant's ego functioning is provided by the mother, in the state of complete dependence. It is only gradually that this environmental provision is gradually internalised. When these functions fail, the infant is faced with the experience of 'falling for ever' or 'falling into pieces' (Winnicott, 1965, p. 57-8). However, ADHD and autistic spectrum conditions are not 'environmental deficiency' states – they are not merely a response to failures of the 'environment mother'. There is a neurobiological substrate that creates unusual needs for environmental ego support – needs which are difficult for mother, fathers, and other family members to meet. These are disorders at the interface of neurobiology and environment – in short, they are (in Kohut's terms) *selfobject disorders*.

People with ADHD particularly experience difficulties with the establishment of the Freudian 'reality principle' in dominance over the 'pleasure principle'. Freud noted that the infant's initial state of helplessness implies a state where he or she has not yet developed a 'reality principle' and is completely dependent on the mother to supply this.

It will rightly be objected that an organization which was a slave to the pleasure-principle and neglected the reality of the external world could not maintain itself alive for the shortest time, so that it could not have come into existence at all. The employment of a fiction like this is, however, justified when one considers that the infant — provided one includes with it the care it receives from its mother — does almost realize a psychical system of this kind. [Freud, 1911b, p. 219, n. 4]

This is a state in which the mother must introduce reality to the child *in small doses* (Winnicott, 1962, p. 74). Indeed, Winnicott's entire elaboration on the role of the environment mother is based around this brief allusion by Freud to the care the infant receives from the mother. What we find in conditions of ADHD and the autistic spectrum is an *abnormal rejection of reality*, even when introduced in Winnicottian 'small doses'. The ADHD/autistic spectrum 'No!' prevails – and there is an insistence on the 'pleasure principle', even though pleasure is often not attained. These traits are indeed linked with a condition called 'Pathological Demand Avoidance Syndrome' – basically a stance of saying 'No!' to everything, perhaps driven by an anxiety-based need to preserve a sense of control (Christie, *et al.*, 2012). In a more

normal ego state, the impingement of reality induces adaptation, but in ADHD this just results in an ever louder 'No!' and spiralling rage and disintegration terror. The spiral of intensifying rage and terror is exacerbated further by the child's expectation, through projection of his or her own need for control, that others will similarly wish to impose *their* need for control.

The person with ADHD tends to experience a lurking dread of chaos, with the ever-present threat of disintegration anxiety, and psychoeconomic dysregulation. On one side of the chasm is the state of feeling bombarded and overwhelmed by internal and external stimulation. On the other side is the equally intolerable state of boredom, of understimulation – leading to addictive pursuits of various kinds, including the active (but unconscious) eliciting of arguments and drama. Self-esteem is always compromised for people with ADHD – caught between the grandiosity of unmodified narcissism and the reality of impaired achievement and repeated experiences of relational and professional failure.

Those with autistic spectrum traits (often 'comorbid' with ADHD) may find almost everything frightening – overstimulated by incoherent fragments of intense sensation. For them, the Markrams' (2010) 'Intense World Theory' seems highly apt. They cannot, of course, easily tell a therapist that this is their experience. To be able to identify this, and find words to describe the experience, is itself a major achievement, one that requires much prior assistance from a psychotherapist. Many psychodynamic compromises and 'defences' may arise from the struggles with an autistic spectrum temperament, but the fundamental condition is not itself a psychodynamic product – and this is important to understand.

Value of the Freudian framework

Psychoanalysis is a comprehensive theory of personality. ... In its most expanded version, metapsychology implies that each psychic phenomenon and its behavioral manifestation can, and must, be stated and understood in genetic, dynamic, structural, economic, topographic, and adaptive terms ... This comprehensive view of man is the strength of classical psychoanalysis as a theory of personality. [Bellack, *et al.*, 1973, p.5]

Various psychoanalytic perspectives – particularly the Freudian concept of the ego and its functions, combined with Kohut's elaboration of the support to the ego provided by the environmental selfobjects – provide a powerful framework for understanding and working with people with ADHD and other conditions where self-regulation is impaired. Many valuable aspects of traditional psychoanalysis, including the work of ego psychologists such as Hartmann (1939) and Jacobson (1965), seem currently out of fashion. A text from over 40 years ago – Bellack and colleagues' (1973) *Ego Functions in Schizophrenics, Neurotics, and Normals* – is a neglected gem, exploring the assessment and treatment of all kinds of impaired ego functioning, and has been a significant influence on the work described here. These authors explore the multiple and varied ways in which the ego attempts to mediate between inner needs and external reality – tasks in which the ego afflicted by ADHD repeatedly fails. The classical psychoanalytic contributions (Freud, 1940a; Couch, 1995; 2002), in my view, provide a depth and range of therapeutic possibilities that greatly exceed those offered by more modern, depleted derivatives of

psychoanalysis, that focus merely on patterns of object relations, clarifications of psychodynamic conflict, or upon helping the client identify the preconscious contents of their mind.

Energy perspectives

Since the writer is an energy psychotherapistⁱⁱ, as well as psychoanalyst and psychologist, I like to look at ADHD also from the perspective of subtle energy (as described in relation to acupuncture meridians, chakras, and other aspects of the human energy system) (Keown, 2014). ADHD clearly displays an imbalance of yin and yang energies. Yang is the outgoing 'masculine' energy, whilst yin is the more inward drawing 'feminine' energy. In the typical hyperactive person with ADHD, the lively yang energy is uncontained, unfocused, and undirected – it is like a firecracker jumping and flashing all over the place causing a great commotion. At the same time, in such a person yin energies are apparent in the tendency constantly (and even greedily) to be looking for, and consuming, novel stimuli and seeking sensation. By contrast, the quieter states of the non-hyperactive but dreamy and distracted person with ADD shows too much yin, unbalanced with sufficient yang. Such people tend to be dysfunctionally passive. People on the autistic spectrum similarly tend to be too yin. In terms of neurotransmitters, dopamine has a yang effect, whilst serotonin has a yin effect. However, these states are not simple matters of too much of one and too little of the other, but more to do with the *balance* between yin and yang, the organisation and flow of the energies, and their concentration in different areas of the body and brain. In a manner analogous to that discussed in relation to the psychoanalytic libidinal and aggressive drives, there appears to be a defusion of yin and yang in ADHD and autistic spectrum states.

Ehlers-Danlos, and other somato-psychic conditions – the disintegrating body self

Another condition that few psychotherapists (or doctors) know much about, and which seems to have some link with states of high sensitivity, is Ehlers-Danlos Syndrome (EDS), or Hypermobility (of joints and connective tissues). It is to do with an inadequacy of collagen in the body, which makes the bones, ligaments, skin, tissue, and organs, less resilient. The body has to work hard to hold itself together with muscular tension. As the condition deteriorates, dislocation of joints may become more frequent, and walking and other movements become increasingly painful. Being alive in such a body creates inherent stress. There can be associated disturbances of (low) blood pressure, cardiac problems, and cognitive deficits. As a result, the person feels continually in danger of *physical and psychological disintegration*. Over the years in which I worked within the NHS, I have known a number of patients with this illnessⁱⁱⁱ. None were diagnosed until many years after they first presented symptoms. Their multiplicity of diverse symptoms had been investigated by different specialists, but typically no-one connected the dots and realised these were all related. They showed the following characteristics: great emotional sensitivity; chronic fatigue; high levels of stress; conscientious and perfectionist; gut problems; pervasive pains. Whilst valuing psychotherapy, they did not get better by normal methods of addressing anxiety, stress, and lifestyle. They did, however, benefit from exploration and understanding of their EDS.

EDS is not the only physical health condition that doctors and mental health practitioners may miss as a result of focusing on the presenting psychological features. Another common illness – and this really does need to be emphasised - is Lyme Disease, caught from infected ticks. If this is not treated quickly and aggressively soon after infection, it becomes Chronic Lyme Disease, manifesting in a range of physical and psychological problems. It can mimic ADHD (Young, 2012; Marzillier, 2009)^{iv}, with cognitive deficits, memory and attentional problems, hyperactivity, racing thoughts, ‘brain fog’, vivid nightmares and intrusive imagery, mood and affect dysregulation, anxiety and depression, and seeming personality disorder – and can also give rise to sensitivities similar to those found amongst people on the autistic spectrum. When a person presents with varied somatic complaints, along with anxiety or depression, it is all too easy for these to be dismissed as ‘psychological’, or to do with ‘stress’, or ‘hysteria’, or as ‘medically unexplained symptoms’. The problems may be ‘medically unexplained’ for the very good reason that the proper diagnosis has not yet been found! With these examples in mind (and there are no doubt many others), I urge psychotherapists, psychiatrists, and medical doctors not to dismiss too easily the role of abnormalities in the person’s brain or body as significant contributors to the presenting clinical picture.

The disturbances described here are not ‘all in the mind’ – they cannot be understood or helped by a purely psychological framework. The workings of the mind are determined in part by the substrate of a compromised brain or body. In working with ADHD, autistic spectrum conditions, EDS and other *somato-psychic* conditions, it is important to understand the dread of falling apart, of losing coherence, of being traumatically overstimulated, or, by contrast, of being in a state of highly aversive understimulation – in short, the myriad terrors and dysphorias of the *disintegrating self*.

ⁱ Some psychoanalytic writers argue that a knowledge of neurobiology has nothing to add to psychoanalytic understanding, and is in fact often an unhelpful distraction from the task of exploring meaning and psychodynamic conflict (e.g. Blass & Carmeli, 2007; Carmeli & Blass, 2013). Such authors assert that neuropsychanalysis provides only neurobiological correlates of psychological processes, and actually tell us nothing of a psychological nature that is not already known. Thus, Carmeli & Blass (2013) state that a “negative consequence of wrongly considering neuroscience to be relevant to psychological change is that it supports the illusion that knowledge of the brain and its plasticity could be therapeutic. Thus we are invited to devote our resources and energy to biological inquiry, while in fact this cannot help.” (p. 408). What I try to describe here is the effect of brain states on ego functions and psychodynamics, and the need to address these brain states in order to engage in any useful exploration of meaning and conflict. Attempts to explain (to the client) ADHD and autistic spectrum traits purely in terms of psychodynamics and unconscious meanings can indeed be harmful, further undermining self-esteem.

ⁱⁱ When I first began introducing energy psychology techniques to psychotherapists, in the early 2000s, these procedures were, in the UK, mostly confined to practitioners of complementary therapies, although in the U.S.A. they were embraced by some leading figures within the clinical psychology mainstream, and particularly by a few ‘early adopters’ and teachers of EMDR. It has been deeply satisfying to observe that by teaching the principles of energy psychology (Mollon, 2005; 2008; 2014) to psychoanalytic (and other) psychotherapists, as well as to clinical psychologists, a lively and developing field of Energy Psychotherapy has been established in Britain.

ⁱⁱⁱ I am most grateful to a client for first drawing my attention to Ehlers-Danlos Syndrome, which previously was completely unknown to me.

^{iv} See also: www.lymediseaseaction.org.uk/about-lyme/neurology-psychiatry/ and www.mentalhealthandillness.com/Articles/LymeDiseaseAndCognitiveImpairments.htm